CT AND IV CONTRAST HISTORY AND SCREENING FORM

Today's Date: ____________ Referring Physician: ______________________________

Patient Name ____ Sex: ☐ Male ☐ Female

DOB: ______________ Age: ____________ Weight: ____________ Height: ____________

Explain your medical problem in detail that is the reason for you having this CAT Scan test today.
(Where is the problem? How long have you had this problem?)

____

____

____

Have you had a previous exam related to this problem? ☐ Yes ☐ No. If yes, where was the exam performed?____________

List other medical problems: ______________________________

List previous surgeries: ______________________________

History of Cancer, where? ______________________________

List all allergies: ______________________________

Is there any possibility of pregnancy? ______________________________

CONTRAST HISTORY

List any daily medications: ______________________________

Are you taking Glucaphage (a diabetic medication)? ☐ Yes ☐ No

BUN__________ CREATININE__________

Have you ever had an allergic reaction to X-ray / CT contrast? ☐ Yes ☐ No

If yes, explain:______________________________

____

Any personal history of:

Asthma	☐ Yes ☐ No	**Family History of Kidney Failure?**	☐ Yes ☐ No	**Current/Recent IV antibiotics**	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	**Thyroid Cancer**	☐ Yes ☐ No	**Currently receiving Dialysis / Blood Transfusions**	☐ Yes ☐ No
Single Kidney or Kidney disease, transplant, failure?	☐ Yes ☐ No	**Multiple Myeloma**	☐ Yes ☐ No		
		Collagen Vascular Disease?	☐ Yes ☐ No	**Are you breast-feeding?**	☐ Yes ☐ No

Comments: ______________________________

____

I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time.

______________________________ **Date** ____________ **Time** ____________

Patient/Parent/Legal Guardian Signature

______________________________ **Date** ____________ **Time** ____________

Witness Signature

Not applicable to this exam ☐

________ CC of ________ With a ____________ at ____________ X ____________

Lot ______________ Expiration Date ______________

Site Location ______________ By______________

Contrast Reaction Yes No Physician Covering Contrast ______________

Explain:______________________________