



CT SCAN
PATIENT HISTORY AND SCREENING

Name: _____ Date of Birth: _____

Date: _____

ALLERGIES: This is important as we may give you an injection during the examination.

Are you allergic to any medications? If so, please list all the medications you are allergic to:

Are you allergic to "x-ray dye (also called "IVP dye", "Radiology dye", or contrast material')? ___ YES ___ NO

If "yes" what reaction did you have? (Check all that apply)

- ___ NAUSEA / VOMITING ___ HIVES ___ DIFFICULTY BREATHING
___ STOPPED BREATHING ___ HEART STOPPED
___ OTHER (please explain) _____

Have you had a CT scan before? ___ YES ___ NO

If "yes" did you have any problems during the examination? ___ YES ___ NO

If "yes", please explain _____

If you have an allergy to "x-ray dye", "IVP dye" have you been pre-medicated for this exam?
This usually means taking three doses of steroids prior to the exam ___ YES ___ NO

RENAL (KIDNEY) FUNCTION:: This is important as the injection may affect your kidneys.

Do you have renal insufficiency or renal failure? ___ YES ___ NO

If "yes", are you on dialysis? ___ YES ___ NO

If "yes", when is your next scheduled dialysis? _____

Do you have any kidney problems? ___ YES ___ NO

If "yes", please explain _____

DIABETES:

Do you have diabetes? ___ YES ___ NO

If "yes", what medication are you taking? (check all that apply)

- ___ INSULIN ___ GLUCOPHAGE ___ METFORMIN ___ GLUCOTROL ___ OTHER _____

PREGNANCY: This is important as the radiation from this exam may be harmful to the baby.

Is there ANY chance AT ALL that you could be pregnant? ___ YES ___ NO

IF THERE IS ANY CHANCE YOU COULD BE PREGNANT, PLEASE TELL THE TECHNOLOGIST BEFORE YOUR EXAM

CT EXAM:

What type of CT exam are you having today? (check all that apply)

HEAD NECK CHEST ABDOMEN PELVIS BACK ARM LEG

Why are you having this exam? (check all that apply and explain)

TRAUMA / INJURY

Why type? When? _____

PAIN

When? How long _____

CANCER

What type? _____

Has it spread? _____

Have you received treatment? (check all that apply)

SURGERY RADIATION CHEMOTHERAPY When? _____

OTHER: (please explain) _____

Have you had other tests to evaluate this problem?

When? What type? _____

PREVIOUS SURGERIES:

Check prior surgeries you have had and give an approximate date of that surgery.

APPENDIX _____ HYSTERECTOMY _____

GALLBLADDER _____ OVARY _____

SINUS _____ BRAIN _____

BOWEL _____

CANCER _____

OTHER (please list all) _____

OTHER MEDICAL PROBLEMS;

Check other medical problems you currently have or have had.

HIGH BLOOD PRESSURE

HEART DISEASE

STROKE

PERIPHERAL VASCULAR DISEASE

SEIZURES

SINUSITIS

HEARING LOSS

THYROID DISEASE

COPD

LUNG DISEASE

PULMONARY EMBOLISM

ARTHRITIS

LIVER DISEASE

HEPATITIS

LUPUS

INFLAMMATORY BOWEL DISEASE

CROHN'S

POLYPS

CANCER (type) _____

SICKLE CELL ANEMIA

MULTIPLE MYELOMA

MYASTHENIA GRAVIS

Patient / Guardian Signature: _____

Date: _____

Technologist Signature: _____