ENHANCED MEDICAL IMAGING

# CT HISTORY SHEET

Patient Name: _____ Phone number:_____

D.O.B. _____HT:_____WT:_____ MRN:_____

Date of exam:_____ Ordering M.D.: _____

Exam Ordered: _____Reason for Exam:_____

Is today's visit due to a Motor Vehicle Accident/or personal injury caused from a third party? Y / N
Is a creatinine needed Y / N ? Was one performed Y / N ?

History of:

Heart Disease Y / N
High Cholesterol Y / N
High Blood Pressure Y / N
Lung Disease Y / N
Asthma Y / N
Smoking Y / N
Kidney Disease Y / N
Are you diabetic? Y / N
If yes, are you taking Metformin or Glucophage drugs? Y / N
Any previous exams of this area? Y / N
What type? _____
Have you had a CT Scan before? Y / N
Of What? _____Where was it performed?_____
Have you ever had an injection of Iodinated contrast? Y / N
If yes, were there any problems or adverse reactions to the contrast? Y / N
Please describe:
_____
Have you ever had any surgery pertaining to area being scanned? Y / N
_____
Do you have any allergies Y / N
If yes, what are they? _____
Are you pregnant right now, or do you think you may be? Y / N
Do you have any history of cancer? Y / N
If yes, what kind? _____
When were you diagnosed? _____
Have you had Radiation or Chemotherapy? Y / N
If yes, where and when was your last treatment?
_____

I understand the benefits and risks of this procedure as explained to me. I have had the opportunity to ask questions. I understand that if I am taking Metformin (Glucopahge or Glucovance), I should stop taking the drug for 48 hours after the procedure.

Patient Signature: _____Date:_____
(Or legal guardian)

To be completed by technologist

BUN: _____CREAT: _____DATE OF DRAW:_____