

CT Screening Form

Patient Name _____ Date _____ Sex: M F Weight _____

DOB: ___/___/___ Type of CT _____ Appointment Date/Time: _____

What complaint/symptoms led you to see your doctor? _____

How long have you had these symptoms? _____

Have you had any previous surgery on the area of interest? _____

Have you had any previous Radiological exams on the area of interest such as Ultrasound/MRI/CT/X-ray at another facility? If so, when and where: _____

Have you ever had radiation or chemotherapy? _____

Please list all allergies: _____

Comments: _____

Please check the appropriate box if you have the following items:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Breast Feeding
<input type="checkbox"/>	<input type="checkbox"/>	Previous Contrast Reaction	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Renal Failure
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Myeloma	<input type="checkbox"/>	<input type="checkbox"/>	Metallic Implants/Prosthesis
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	History of Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/hay fever	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to IV dye, latex, seafood
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	History of pheochromocytoma

***Are you currently taking any of the following medications: Metformin, Glucophage, Glucovance, Avandamet, or Metaglip. Yes No

Female Patients Only: Test will normally be rescheduled if there is any chance of pregnancy!
 I am not pregnant, my last menstrual period was _____

Radiology Use Only: Creatinine Level _____ Draw Date _____
Contrast Used: Omnipaque or Visipaque
Volume: _____ Rate: _____ IV Site _____
Reaction: No Yes: If yes, fill out reaction form

Patient/Parent/Legal Guardian Signature: _____ Date: _____