CT and IV Contrast History and Screening Printable Form

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____ Sex: ○M / ○F

Are You Pregnant? ○Yes ○No ○N/A Are you Breast Feeding at this time? ○Yes ○No

Date of Last Menstrual Period: _____

Reason you are here for an exam today? Explain your medical problem in detail. (What is the problem? 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, what type of exam? _____

Where was exam? _____ When was exam? _____

List other medical problems: _____

List previous surgeries: _____

Medications presently taking: _____

List any Drug or Food Allergies: _____

Contrast History: ☐Not applicable to this exam

Are you taking Metformin or Glucophage? ○Yes ○No BUN_____ CREATININE_____

HAVE YOU EVER HAD A PREVIOUS ALLERGIC REACTION TO IV X-RAY CONTRAST (DYE)?

○Yes ○No If yes, explain: _____

Have you been pre-medicated for this exam? ○Yes ○No

PERSONAL HISTORY:

Asthma	○Yes	○No	Dizziness	○Yes	○No
Allergic Respiratory Disease	○Yes	○No	Heart Disease	○Yes	○No
Diabetes	○Yes	○No	Stroke	○Yes	○No
Kidney Disease	○Yes	○No	Liver Disease	○Yes	○No
Cancer	○Yes	○No	Seizure Disorder	○Yes	○No
Multiple Myeloma	○Yes	○No	Bladder Disease	○Yes	○No
Prostate Problems	○Yes	○No	Headaches	○Yes	○No
Anemia\Sickle Cell	○Yes	○No			

If yes to any of the above questions please explain: _____

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.

_____ _____ _____

Patient/Parent/Legal Guardian Signature | Technologist's Signature | Date