

Outpatient Diagnostic Center

CT and IV Contrast History & Screening Form

DATE _____

PATIENT _____

SEX: M F

WEIGHT _____ HEIGHT _____ DOB ___/___/___ AGE _____

Explain in detail your medical problem that is the reason for the 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: _____

List all allergies: _____

CONTRAST HISTORY

Are you taking Glucophage? ___ YES ___ NO BUN _____ CREATINE _____

Have you ever had an allergic reaction to X-Ray contrast? ___ YES ___ NO

If yes, explain _____

Any personal history of:

Asthma ___ YES ___ NO

Diabetes ___ YES ___ NO

Kidney Disease ___ YES ___ NO

Cancer ___ YES ___ NO

Sickle Cell Anemia ___ YES ___ NO

Are you Breast Feeding ___ YES ___ NO

Last Menstrual Cycle Date _____

Multiple Myeloma ___ 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.***

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE

TECHNOLOGIST/WITNESS SIGNATURE

DATE

NOT APPLICABLE TO THIS EXAM

_____ cc of _____ with a _____ @ _____ X _____

Amount Type of Contrast GA & Needle Type Time # of Punctures

In _____ Lot# _____ Expiration Date: _____ By: _____

Site Location

CONTRAST REACTION: ___ YES ___ NO PHYSICIAN COVERING CONTRAST _____

EXPLAIN: _____