



Please answer ALL questions that pertain to the procedure you are having performed today

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex M F DOB \_\_\_\_\_ Weight \_\_\_\_\_

Have you had a prior CT? (Please list facility and date)

\_\_\_\_\_

Any injury to this body part? \_\_\_ Yes \_\_\_ No Any Surgery? \_\_\_ Yes \_\_\_ No (If yes please give a brief description)

\_\_\_\_\_

Are you experiencing pain? \_\_\_ Yes \_\_\_ No (Explain) \_\_\_\_\_

\*\*Have you had any prior studies of any kind pertaining to today's exam? If yes, when and where?

\_\_\_\_\_

**History & Physical (\*):**

|  |   |   |
|--|---|---|
| <input type="checkbox"/> Cancer (type) _____         | <input type="checkbox"/> Smoker ___ Quit                  | <input type="checkbox"/> Liver Disease                          |
| <input type="checkbox"/> Radiation**                 | <input type="checkbox"/> Difficulty walking straight line | <input type="checkbox"/> Sickle Cell                            |
| <input type="checkbox"/> Chemo                       | <input type="checkbox"/> Difficulty holding bladder       | <input type="checkbox"/> Multiple Myeloma                       |
| <input type="checkbox"/> **Finished ___ Still taking | <input type="checkbox"/> Redness/Discoloration            | <input type="checkbox"/> Head Surgery                           |
| <input type="checkbox"/> Stroke (Year) _____         | <input type="checkbox"/> Lump/Swelling/Mass               | <input type="checkbox"/> Heart Surgery                          |
| <input type="checkbox"/> Headache                    | <input type="checkbox"/> Blood in urine                   | <input type="checkbox"/> Lung Surgery                           |
| <input type="checkbox"/> Seizure                     | <input type="checkbox"/> Blood in stool                   | <input type="checkbox"/> Gallbladder Surgery                    |
| <input type="checkbox"/> Vision Loss ___ R ___ L     | <input type="checkbox"/> Microscopic Blood                | <input type="checkbox"/> Hysterectomy                           |
| <input type="checkbox"/> Memory Loss                 | <input type="checkbox"/> Fever                            | <input type="checkbox"/> Aneurysm                               |
| <input type="checkbox"/> Hearing Loss ___ R ___ L    | <input type="checkbox"/> Asthma 493.90*                   | <input type="checkbox"/> Colon Surgery                          |
| <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Hayfever 995.3*                  | <input type="checkbox"/> Allergies* (Biological, or drug)995.2* |
| <input type="checkbox"/> Cough                       | <input type="checkbox"/> Heart Disease 428.0*             | <input type="checkbox"/> Diabetic 250.00*                       |
| <input type="checkbox"/> Coughing Blood/Phlegm       | <input type="checkbox"/> High Blood Pressure 402.90*      | <input type="checkbox"/> Other _____                            |
| <input type="checkbox"/> Numbness                    | <input type="checkbox"/> Lung Disease 518.83*             |   |
| <input type="checkbox"/> Weakness                    | <input type="checkbox"/> Kidney Disorder 586*             |   |

Some tests require Contrast-Please answer the following questions concerning reactions.

1. Have you ever had a reaction to ISOVUE (CT/IVP Contrast) \_\_\_ Yes \_\_\_ No
2. If "Yes" \_\_\_ Hives \_\_\_ Shortness of breath \_\_\_ Fainting/Dizzy \_\_\_ Other (Explain) \_\_\_\_\_
3. Are you a Diabetic Y N Do you take: \_\_\_ Glucophage \_\_\_ Metformin \_\_\_ Glucovance \_\_\_ Insulin

**FEMALE PATIENTS ONLY – TECHNOLOGIST WILL ASK YOU AGAIN BEFORE EXAM**

Any Chance of Pregnancy \_\_\_ Yes \_\_\_ No Date of Last Menstrual Cycle \_\_\_\_\_

Please mark all that apply: \_\_\_ Breast-Feeding \_\_\_ Using IUD \_\_\_ Birth Control Pills \_\_\_ Hysterectomy \_\_\_\_\_ (Date)

SIGNATURE: \_\_\_\_\_

Date: \_\_\_\_\_

Please list any additional information you feel would be pertinent to today's exam.

\_\_\_\_\_

I understand the procedure and possible complications regarding the study I am having and hereby consent to the administration of intravenous and/or oral contrast media.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_