FLORIDA RADIOLOGY CONSULTANTS
Your choice for advanced health imaging

CT Medical History

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 (*):

___Cancer *(type)* _____
___Radiation**
___Chemo
___**Finished___Still taking
___Stroke *(Year)* _____
___Headache
___Seizure
___Vision Loss ___ R___ L
___Memory Loss
___Hearing Loss ___ R___ L
___Dizziness
___Cough
___Coughing Blood/Phlegm
___Numbness
___Weakness
___Smoker ___Quit
___Difficulty walking straight line
___Difficulty holding bladder
___Redness/Discoloration
___Lump/Swelling/Mass
___Blood in urine
___ Blood in stool
___Microscopic Blood
___Fever
___Asthma **493.90***
___Hayfever **995.3***
___Heart Disease **428.0***
___High Blood Pressure **402.90***
___Lung Disease **518.83***
___Kidney Disorder **586***
___Liver Disease
___Sickle Cell
___Multiple Myeloma
___Head Surgery
___Heart Surgery
___Lung Surgery
___Gallbladder Surgery
___Hysterectomy
___Aneurysm
___Colon Surgery
___Allergies* (Biological, or drug)**995.2***
___Diabetic **250.00***
___Other_____

Do you have both of your kidneys? Y N Are they functioning well? Y N

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

1. Have your ever had a reaction to Iodine (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_____