CT SCREENING FORM

NAME:_____DATE:_____
Please circle or fill in the following answers to these important questions so that the Radiologist can better interpret your exam.

What is the reason for the test you are having today? Nausea Vomiting Diarrhea Constipation Difficulty Urinating Kidney Disorder Shortness of Breath Cough Dizziness

Pain-Location:_____ Other symptoms?_____

Do you have a history of any medical problems? Yes No If yes, please explain._____

Do you have any ALLERGIES to medication/contrast dye/shell fish? Yes No If yes, please list them:_____

Have you ever had an injection of IV contrast (dye)? Yes No
Have you ever had a reaction to IV contrast (dye)? Yes No
What type of reaction? Itching Hives Swelling Difficulty Breathing Other:_____
Do you now or have you ever smoked cigarettes? Yes No _____packs/day for_____years
Do you now or have you ever had any of the following: High Blood Pressure Diabetes Kidney Failure/Insufficiency Asthma

Please list any Medications you are currently taking:_____
_____

Have you had any Surgery performed in the area we are examining today? Yes No
Open Heart/Gallbladder/Appendix/Thyroid/Hysterectomy(total partial)/Prostate/Bladder D&C/C-Section/Tubal Ligation/Masectomy (R L)/Lumpectomy/Lymph Node/Liver Stent/Kidney (R L)/Prosthesis/Tonsils Other:_____

Have you ever had Cancer? Yes No If yes, what type:_____When:_____
Chemotheraphy? Yes No Radiation Therapy? Yes No

Any possibility that you may be pregnant? Yes No Date of your last period:_____

_____ _____ _____
Patient Signature Guardian Signature Date

TECH NOTES:

CONTRAST USED: Scan-C Optiray 300 100ml 50ml Other_____ None