CT and IV Contrast History and Screening Printable Form



Patient Name:				Date:		
			ıt: Height:			
Are You Pregnant?	Yes No	N/A	Are you Breast Feeding at thi	is time? Y	es No	
Date of Last Menstr	ual Period:					
Reason you are here for an the problem? How long ha	-		ur medical problem in detail. (' ?)			
Have you had a previous ex	am related to	this probl	em? Yes No			
If yes, what type of e	exam?					
Where was exam? _			When was exam?			
List other medical problem	1S:					
Medications presently takir	ng:					
Contrast History: Not app	olicable to this	s exam				
HAVE YOU EVER HAD A P	REVIOUS ALL xplain:	ERGIC RE	ACTION TO IV X-RAY CONTRA	AST (DYE)?		
PERSONAL HISTORY:						
Asthma	Yes	No	Dizziness	Yes	No	
Allergic Respiratory Disease	e 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 q	uestions pleas	se explain:				
I have answered these que I have also informed the te		_	knowledge and understand the pregnant at this time.	e informatio	on presented to me	
Patient/Parent/Legal Guardian Sig	nature		Technologist's Signature		Date	