

CT HISTORY

Patient Name (Printed): _____ Birth Date: _____

Acct.#: _____

INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

- | | | | |
|---------------------|--|------------------------------|--|
| Seizure Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, are you taking | |
| Multiple Myeloma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metformin (e.g., Glucophage) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sickle Cell Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Adrenal Gland Tumor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Active Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Are you pregnant or suspect that you might be pregnant? Yes No

Date of last menstrual period: _____

Do you have a history of kidney (renal) disease, including kidney disease secondary to collagen vascular disease (Lupus, Scleroderma, etc.) or multiple myeloma? Yes No

Have you ever had any adverse reaction to CT or X-ray contrast material (dye) *other* than a sensation of warmth, flushing, or a single episode of nausea? Yes No

If yes, please explain: _____

Do you have any allergies including drug allergies? Yes No

If yes, what are you allergic to: _____

DESCRIBE YOUR SYMPTOMS OR THE REASON YOU ARE HAVING TODAY'S CT SCAN:

HAVE YOU HAD A PREVIOUS X-RAY, CT OR MRI OF THE AREA BEING SCANNED TODAY?

If yes, list below what was done and where it was performed:

I understand the above information and I have answered the questions to the best of my knowledge. I have had the opportunity to ask questions about the information on this form that I did not understand.

Patient Signature

Date



OPTIMAL IMAGING
St. Vincent's HealthCare

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CT ■ DEXA ■ MRI ■ Wellness Imaging ■ X-Ray ■ Ultrasound