PLACE PATIENT ID LABEL HERE

CT PATIENT HISTORY QUESTIONNAIRE

(Please circle and fill in all the way across the page.)

Arrived by: _________ Checked by: _________

Patient Name______________________________________ Date ____________________

Age ____ Weight __________________

Please list the symptoms and reason for this exam: ________________________________

____

Does your history include any of the following? If yes, please explain in the space provided

Previous scans or x-rays? No Yes ____________________________

What type of study ____

When ___________________________ Where ____________________________

Are you pregnant or breastfeeding? No Yes ____________________________

Adverse reaction to contrast material No Yes ____________________________

(sensation of heat, flushing or single episode of nausea or vomiting does not count)

Allergies: Medication No Yes ____________________________

Food No Yes ____________________________

Environment No Yes ____________________________

Heart Disease No Yes If yes, please circle if you have any of the following:

Severe arrhythmia, unstable angina pectoris, recent or imminent cardiac decompensation, recent heart attack, pulmonary hypertensions

Asthma No Yes ____________________________

Diabetes No Yes If yes, list medication ____________

____

High Blood Pressure No Yes ____________________________

Kidney disease No Yes ____________________________

Kidney removed No Yes ____________________________

Cancer No Yes ____________________________

Multiple myeloma No Yes ____________________________

Sickle cell disease No Yes ____________________________

Any other disease No Yes ____________________________

Hysterectomy No Yes ____________________________

Ovaries removed No Yes ____________________________

Any other surgery No Yes ____________________________

____

Generalized severe debilitation No Yes ____________________________

To the best of my knowledge, the above information is correct.

Patient's Signature____________________________________ Date ____________________

*****To be completed by AIC personnel only *******

Creatinine level ______________________ Date drawn ____________ Tech/RN__________

Contrast type and amount____