CT HISTORY FORM

Patient Name: ____

DOB: ____________________ Age: __________________ Height: _____________ Current weight: _____________

Have you had a previous imaging study related to this problem? □ **Yes** □ **No**

If yes. What exam? □ **CT** □ **MRI** □ **Ultrasound** □ **X-ray** □ **Other** What Facility? ___________________________

PERSONAL HISTORY

□ **Yes** □ **No** Heart Disease

□ **Yes** □ **No** Asthma/Other Lung Disease

□ **Yes** □ **No** Diabetes

□ **Yes** □ **No** Smoking

□ **Yes** □ **No** High Blood Pressure

□ **Yes** □ **No** Kidney Disease/ Kidney Failure

□ **Yes** □ **No** Dialysis

□ **Yes** □ **No** Allergies If yes, please specify: ____

□ **Yes** □ **No** Surgeries If yes, please specify: ____

□ **Yes** □ **No** Cancer If yes, please specify: ____

□ **Yes** □ **No** Do you take Metformin hydrochloride (Glucophage, Glucovance, Avandement, Metaglip, or Fortamet?)

□ **Yes** □ **No Have you ever had a allergic reaction to injected contrast (x-ray dye)?** If yes, please explain your reaction:____

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding? □ **Yes** □ **No** Date of last period: ______________________________

ACKNOWLEDGEMENT

I have answered these questions to the best of my knowledge and understand the information presented to me. If I am to have intravenous con-trast with my procedure, I have been informed of the risks.

Patient/ Guardian Signature: _______________________________ Date: ______________________________________

Technologists Signature: __________________________________ Date: ______________________________________