OUTPATIENT DIAGNOSTIC CENTER

CT History Form

PATIENT INFORMATION **Fall Precaution** ☐ YES ☐ NO

Last Name	First Name/Middle Initial	Gender	Race
Date of Birth (MM/DD/YYYY) / /	**Age**	**Height**	**Weight**

PERSONAL HISTORY

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? _____

How many CT exams have you had in the last 12 months? _____

How many Cardiac Nuclear Medicine Studies have you had in the last 12 months? _____

Heart Disease	☐ YES ☐ NO	**High Blood Pressure**	☐ YES ☐ NO	**Kidney Disease**	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	**Smoking**	☐ YES ☐ NO	**Kidney Failure**	☐ YES ☐ NO
Lung Disease	☐ YES ☐ NO	**Diabetes**	☐ YES ☐ NO	**Dialysis**	☐ YES ☐ NO

Allergies ☐ YES ☐ NO If yes, please explain: _____

Surgeries ☐ YES ☐ NO If yes, please explain: _____

Cancer ☐ YES ☐ NO If yes, please explain: _____

Do you take Metformin hydrochloride (Glucophage, Glucovance, Advandement, Metaglip, or Fortamet)? ☐ YES ☐ NO

Have you ever had an allergic reaction to injected contrast (x-ray dye) ☐ YES ☐ NO

If yes, please explain: _____

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: _____

ACKNOWLEDGMENT

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

_____ _____

PARENT/ GAURADIAN SIGNATURE **DATE**

_____ _____

TECHNOLOGIST SIGNATURE **DATE**