CT History and Screening Form

Last Name:	First Name:	Middle Init:	Date of Birth:

Are You Pregnant? ☐Yes ☐No ☐N/A Last Menstrual Period: ________________________________

Please explain your medical problem or reason why you visited your doctor:
Where is the problem? ____
What is the problem? ____
How long have you had this problem? ____________________________________

Have you had a previous exam related to this problem? ☐Yes ☐No What type of exam? ______________
If Yes, When was the exam? _____________ Where was the exam done? ___________________________

List previous related surgeries: ____
Medications presently taking: ____

CONTRAST HISTORY:
Are you taking Glucaphage? ☐Yes ☐No
If yes, discontinue the day of the exam and for 48 hours after the exam.

HAVE YOU EVER HAD A PREVIOUS ALLERGIC REACTION OF X-RAY CONTRAST (DYE)? ☐Yes ☐No
If Yes, Have you been pre-medicated for this exam? ☐Yes ☐No

List any Drug or Food Allergies: ____

PERSONAL HISTORY:

☐Yes	☐No	Asthma	☐Yes	☐No	Dizziness
☐Yes	☐No	Allergic Respiratory Disease	☐Yes	☐No	Heart Disease
☐Yes	☐No	Diabetes	☐Yes	☐No	Stroke
☐Yes	☐No	Diabetic Nephropathy	☐Yes	☐No	Cardiomyopthy
☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Anxiety
☐Yes	☐No	Kidney Disease/Renal Failure	☐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	Are you Breast Feeding at this time?	☐Yes	☐No	HIV/AIDS

If yes, please explain: ____

I have answered the questions to the best of my knowledge and have informed the technologist that I am not pregnant at this time.

_________________	______________________________	____________________
Date	Patient or Legal Guardian (please sign)	Relationship