PATIENT HISTORY FORM FOR CT EXAMS

Type of exam:_____

What symptoms are you currently having?_____
_____

Do you have any major medical problems?

Asthma	____ Yes	____ No
Kidney Failure	____ Yes	____ No
Multiple Myeloma	____ Yes	____ No
Sickle Cell Anemia	____ Yes	____ No
Polycystic Ovarian Syndrome	____ Yes	____ No
Heart Disease	____ Yes	____ No

If you have heart disease, please list the medications you take
_____

Do you have or have you had any kidney problems:_____
Who is your kidney physician?_____

Explanations of medical problems listed above:_____
_____

Do you have any allergies? _____Yes _____No
If yes, please list_____
Do you have Diabetes? _____ Yes _____No
If yes, do you take Fortamet, Glucophage/(XR), Glumetza, Riomet, Metformin, Avandamet, Metaglip, Glucovance, Actoplus Met, Prandimet, Janumet or Generics of these medication?_____ Yes _____ No

Have you ever had cancer? _____ Yes _____ No
If yes, please answer the following:
What type:_____
When were you diagnosed:_____
What treatment were you given:_____

Have you had IV contrast (X-ray dye/IODINE) in the past? ____ Yes ____ No
If yes, did you experience a problem with the contrast? ____ Yes ____ No
If yes, what type problem did you have?_____
Do you have Mastocytosis? ____ Yes ____ No

Is there any possibility you might be pregnant? ____Yes ____No
Do you or have you used tobacco products? ____Yes ____No For how long?_____

Have you had surgery on your chest, abdomen or pelvis? ____Yes ____No
If yes, please explain_____

Patient Signature_____ **Date**_____

To be completed by the technologists- Required

Contrast used:
[] Omnipaque 300
[] Omnipaque 350
[] Visipaque 320
[] Other:_____

Quantity:
[] 100 ml [] 150 ml
[] 120 ml [] 125 ml
[] Other:_____

Injection Site:
[] Existing IV [] Porta Cath
[] IV inserted [] Power Picc/Port
Other:_____

Injector used: [] Yes [] No

Injection rate: _____

Injection Time: _____

Creatine Level (if indicated) _____ Date Performed_____
BUN Level (if indicated) _____ Date Performed_____
GFR Level (if indicated) _____ Date Performed_____

Bottom Section to be filled out in cases of Contrast Reaction and/or Extravasation Only

Post-Assessment

Was there a Contrast Reaction with this exam:
[] NO []YES

If Yes, Type of reaction:
[] Hives [] N/V
[] Sneezing [] Other

Was there an Extravasation: [] No [] Yes

List medications given:

[] None
[] Benadryl _____mg
[] Epinephrine _____mg
[] Solu-Medrol _____mg
Other:_____

Physician notified of contrast reaction / extravasation:

Tech Signature: _____ Date: _____

BARCODE

1-WS0000