

 **CT Patient History and Screening Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Acct #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Follow-up Appt with MD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the reason for this exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have had these symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking medications for these symptoms: YES NO If yes, what:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of cancer? YES NO If yes, what type and when were you diagnosed:\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Surgeries (please circle)

 Y N Gallbladder Y N Appendix Y N Stomach

 Y N Colon Y N Small Bowel Y N Hysterectomy

 Y N C-Section Y N Kidneys Y N Liver

 Y N Ovaries Y N Hernia Y N Prostate

 Y N Brain Y N Head/Neck Y N Esophagus

 Y N Heart Y N Breast Y N Lung

Other Surgeries, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or have you ever smoked: Y N Have you ever had a head injury: Y N

Do you have a history of kidney stones: Y N Do you have a history of seizures: Y N

Do you have blood in your urine: Y N Do you have any vision changes: Y N

Do you have abdominal pain: Y N

Have you had a previous X-Ray, CT Scan or MRI: Y N If yes, please list the date and most recent studies: Type of Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following medical conditions: (please circle)

 Y N Diabetes Y N High blood pressure & age over 65

 Y N Multiple myeloma Y N Renal (kidney) insufficiency/failure

 Y N Sickle Cell Anemia Y N Polycythemia

 Y N Pheochromocytoma Y N Collagen Vascular Disease

 Y N Allergies/Asthma Y N Heart Disease

Have you been given an X-Ray dye/contrast injection before: Y N

If yes, which study: (please circle) CT Scan IVP Cardiac Cath Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been given an X-Ray dye/contrast injection within the past 24 hours: Y N

Have you had an allergic reaction to X-Ray Dye/Contrast: Y N

If yes, please describe the contrast and reaction if possible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have a latex allergy: Y N Have you eaten in the last four hours: Y N

Is there any chance you could be pregnant: Y N

Do you have Heart Disease: Y N If yes, please specify: (please circle)

Angina at rest or upon exertion Recent Heart Attack (within 2 weeks) Arrhythmia (uncontrolled by meds)

Heart Failure (shortness of breath at rest or upon mild exertion) Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any of the following medications: (please circle)

 Y N Glucophage Y N Metformin Y N Glucovance Y N Insulin

 Y N Anti-inflammatory drugs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Antibiotics:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Y N Any other oral diabetes medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Technologist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_