DEPARTMENT OF RADIOLOGY
1-888- 656-4723

CT Screening

Patient Name: ______________________________ DOB: ____________________________

Date: _____________________________________ NextGen #_________________________

Referring MD: _____________________________ Weight:___________________________

Type of Scan:____

Briefly describe why you are having this exam:____

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1. Have you ever had a CT scan with intravenous contrast material (X-ray dye)?	Yes	No
2. Do you have any allergies to food or any medications?	Yes	No
If yes, specify: ____		
3. Any history of severe skin itching or hay fever?	Yes	No
4. Do you have any significant cardiac disease?	Yes	No
(Myocardial Infarction, Congestive Heart Failure, Angina, Valvular Heart Disease)		
5. Do you have multiple myeloma? (Bone Marrow Cancer)	Yes	No
6. Do you have Sickle Cell Anemia?	Yes	No
7. Do you have any Kidney Disease/Solitary Kidney/ Renal Transplant?	Yes	No
8. Do you have a Pheochromocytoma? (Adrenal tumor)	Yes	No
9. Do you have High Blood Pressure?	Yes	No
10. Females - Any chance of pregnancy? Last Menstrual Period _______________	Yes	No

Current Medications? ____

Patient/Guardian Signature____Date______________

Printed Name (if other than Patient)__________________________________

Relationship (if other than Patient)___________________________________