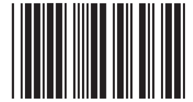

For Office Use Only
Place Patient ID label here

COMPUTED TOMOGRAPHY (CT) CLINICAL INFORMATION

Patient name ____________________ ○ Female ○ Male

Body part to be scanned ____________________ Exam date ____________

Reason for exam ____________________

____

____

Please list all medications you are currently taking ____________________

____

○ Y ○ N Have you had previously related studies (nuclear scan, x-ray, ultrasound, CT, MRI or PET)? If yes, please explain and bring studies to your appointment.

Type of exam	Where	When	Results

Comments ____________________

○ Y ○ N Have you had any surgery or therapy? If yes, explain type and when. ____________________

____

For female patients only: Date of last menstrual period ____________________

○ Y ○ N Are you nursing? ○ Y ○ N Are you possibly pregnant? (*If yes, notify technologist immediately.*)

Patient signature: ____________________ Date: ____________

CONTRAST QUESTIONNAIRE: Have you had, or do you have any of the following?

○ Y ○ N Previous reaction to contrast (*If yes, notify RN immediately.*)
○ Y ○ N Allergies
○ Y ○ N Infectious diseases
○ Y ○ N History of heart disease (arrythmia, congestive heart failure, angina, myocardial infarction)
○ Y ○ N Hypertension
○ Y ○ N Asthma
○ Y ○ N Diabetes mellitus
○ Y ○ N Multiple myeloma
○ Y ○ N Pheochromocytoma
○ Y ○ N Renal failure
○ Y ○ N Sickle cell disease
○ Y ○ N Smoker
○ Y ○ N Non-smoker
○ Y ○ N Ex-smoker
○ Y ○ N Interleukin 2 (received within the last 2 weeks)
○ Y ○ N Interleukin 2 (expect to receive treatment today or tomorrow)

If yes to any of the above, please explain: ____________________

____

Technologist/RN: ____________________ Date: ____________

FOR OFFICE USE ONLY

Contrast Lot # ____________ Exp. Date ____________ Injected by ____________

Contrast Dose ____________ IV Site ____________ Time ____________

Reaction ____________________

CTCLIN 1109