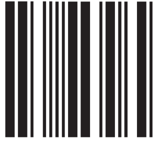
Washington Radiology Associates, P.C.

Computed Tomography Clinical Info.



Acct # ______________________ Tech's/R.N.'s Init./Exam Date ________ / ________

Patient's Name ______________________ Referring Physician ______________________

Date of Birth ______________ Age ________

Body Part To Be Scanned ______________________

DIAGNOSIS/Symptom(s)/Reason for Scan ______________________

List all medications ______________________

Have you had previously related studies: nuclear scan, x-ray, ultrasound, CT, MRI or PET? ◯ Yes ◯ No

If yes, type of exam?	where?	when?	results?

Comments ______________________

Have you had any surgery or therapy? ◯ Yes ◯ No If yes, please explain type and when.

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FOR WOMEN ONLY: Date of last menstrual period ______________ Are you nursing? ◯ Yes ◯ No

Are you possibly pregnant? ◯ Yes ◯ No (If yes, notify technologist immediately)

Patient's Signature ______________________ Date ______________

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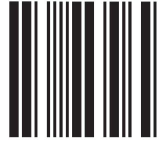

Contrast Questionnaire: Please Check Appropriate Answer

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

Yes	No		Yes	No		Yes	No	
○	○	Previous Reaction to Contrast	○	○	Asthma	○	○	Smoker
○	○	Allergies	○	○	Diabetes Mellitus	○	○	Non-Smoker
○	○	Infectious Diseases	○	○	Multiple Myeloma	○	○	Ex-Smoker
○	○	History of Heart Disease: Arrythmia, Congestive Heart Failure, Angina, Myocardial Infarction	○	○	Pheochromocytoma	○	○	Interleukin 2 (received in the last 2 weeks?)
○	○	Hypertension	○	○	Renal Failure	○	○	Interleukin 2 (expected to receive treatment today or tomorrow?)
			○	○	Sickle Cell Disease			

If yes to any of the above, please explain. ______________________________

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Tech's/R.N.'s Signature ______________________________

Contrast Lot # ____________ Exp. Date ____________ Injected by ____________

Contrast Dose ____________ IV Site ____________ Time ____________

Reaction: ______________________________

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