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Advanced Medical Imaging

CT SAFETY SCREENING &
MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____
Date of Birth:_____

Because of the presence of radiation and the potential for use of a contrast agent (dye), we must have an accurate medical and surgical history.

PLEASE ANSWER THE QUESTIONS BELOW

☐ Yes ☐ No Have you ever had an allergic reaction to CT or X-Ray contrast (dye) before?

If yes, please describe your reaction and the treatment: _____

☐ Yes ☐ No Is there any possibility that you are pregnant? LMP_____(date) Hysterectomy?_____(date) Birth control_____(type)

☐ Yes ☐ No Are you diabetic? If yes, please list treatment: _____

☐ Yes ☐ No Do you have, or have you ever had, kidney disease or kidney transplant?

☐ Yes ☐ No Are you on chemotherapy? If yes, please list your medications and date of last dose: _____

☐ Yes ☐ No Have you received CT or X-Ray contrast (dye) within the last 72 hours?

☐ Yes ☐ No Are you being treated for high blood pressure (hypertension)?

☐ Yes ☐ No Do you have Multiple Myeloma?

☐ Yes ☐ No Do you have sickle cell anemia?

☐ Yes ☐ No Are you taking hydroxyurea?

IF "YES " OR YOU ARE UNSURE ABOUT ANY OF THE ABOVE QUESTIONS , PLEASE TELL THE FRONT DESK STAFF IMMEDIATELY .

☐ Yes ☐ No Do you have asthma?

☐ Yes ☐ No Do you have seasonal or medication allergies? If Yes please list:_____

☐ Yes ☐ No Are you currently taking any medication? If so please list:_____

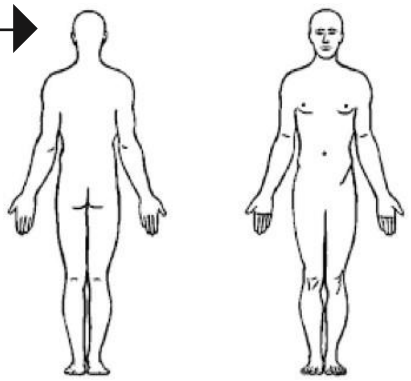
_____

What is your current weight? _____

What is the reason for this exam?_____

☐ Yes ☐ No Are you currently having symptoms? If yes, for how long?_____

PLEASE MARK THE LOCATION OF YOUR SYMPTOMS →



☐ Yes ☐ No Have you ever had cancer? When? _____ Where? _____

☐ Yes ☐ No Do you smoke, or have a history of smoking?

☐ Yes ☐ No Have you had an injury to the area we are scanning today?

If yes: When: _____ What happened?: _____

☐ Yes ☐ No Have you had any surgeries? If yes please list what surgery and year:

_____

Other Medical History?_____

_____

Patient or Guardian Signature: _____ Date: _____

Name and relationship of person filing out this form if other than patient: _____
(please print)

FOR TECHNOLOGIST ONLY

Technologist Signature_____ Date:_____

Contrast Name:_____ Dose:_____ Time:_____ IV location_____