CT History

Patient Name (Printed): _____

Birth Date: _____/_____/_____ Age: _____ Height: _____ Weight: _____

INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Seizure Disorder	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	If yes, are you taking		
Multiple Myeloma	☐ Yes	☐ No	Metformin (e.g., Glucophage)	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Adrenal Gland Tumor	☐ Yes	☐ No	Active Gout	☐ Yes	☐ No

Are you pregnant or suspect that you might be pregnant? ☐ Yes ☐ No

Date of last menstrual period: _____

Do you have a history of kidney (renal) disease, including kidney disease secondary to collagen vascular disease (Lupus, Scleroderma, etc.) or multiple myeloma? ☐ Yes ☐ No

Have you ever had any adverse reaction to CT or X-ray contrast material (dye) *other* than a sensation of warmth, flushing, or a single episode of nausea? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any allergies including drug allergies? ☐ Yes ☐ No

If yes, what are you allergic to: _____

DESCRIBE YOUR SYMPTOMS OR THE REASON YOU ARE HAVING TODAY'S CT SCAN:

_____

_____

HAVE YOU HAD A PREVIOUS X-RAY, CT OR MRI OF THE AREA BEING SCANNED TODAY?

If yes, list below what was done and where it was performed:

_____

_____

I understand the above information and I have answered the questions to the best of my knowledge.
I have had the opportunity to ask questions about the information on this form that I did not understand.

_____ _____

Patient Signature Date

Optimal Imaging | Sacred Heart Health System

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