CT Patient History and Safety Screening

Please describe your symptoms / Why are you here?

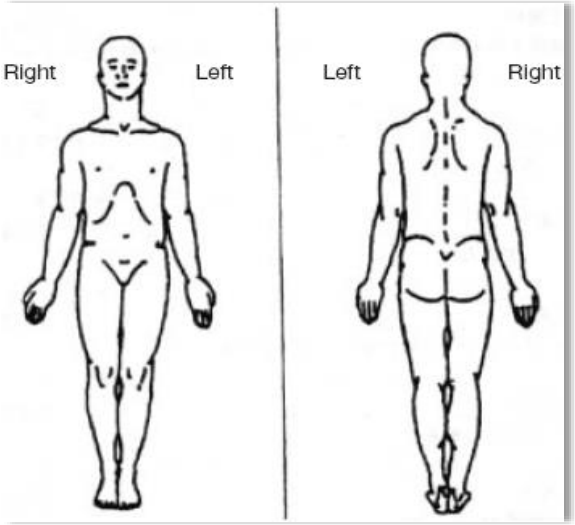
_____

_____

_____

_____

_____



Please place an "X" over affected area(s) by pain on diagram to the right:

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 contrast (dye)? If yes, please describe your reaction and the treatment: _____

❑ Yes ❑ No Is there any possibility you are pregnant?

❑ Yes ❑ No Are you diabetic?

❑ Yes ❑ No Do you have chronic kidney disease? (please circle)

a. History of prior dialysis
b. Kidney transplant
c. Single kidney
d. Renal cancer
e. Renal surgery (this does **not** include kidney stones)

❑ Yes ❑ No Do you have high blood pressure that requires medication?

❑ Yes ❑ No Are you taking hydroxyurea?

❑ Yes ❑ No Do you have asthma?

❑ Yes ❑ No Do you have any allergies, including medications? If yes, list allergies: _____

_____

Signature of patient: _____ **Date:** _____

Name of the person filling out this form, if other than the patient (please print): _____

Relationship to the patient (please print): _____

Technologist Initials: _____

Affix Pt Sticker Here

Creat_____ GFR___ Date_____

(6/18)