

PATIENT INFORMATION

NAME _____ DOB _____ HEIGHT _____ WEIGHT _____

BODY PART TO BE EXAMINED _____ REFERRING PHYSICIAN _____

REASON FOR CT / CTA (SYMPTOMS AND/OR CONDITION) _____

SAFETY SCREENING

1. Have you ever had a prior surgery or operation of any kind? YES NO
If "Yes," please give a brief description of the type and date of the surgery: _____
2. Have you had a prior MRI, CT, Ultrasound, X-ray, etc.? YES NO
If "Yes," please list type, date, and the facility where it was performed: _____
3. Have you ever experienced any problems related to a previous CT examination? YES NO
If "Yes," please describe: _____
4. Do you have any conditions and/or disease(s) of your heart? YES NO
If "Yes," please list: _____
5. Are you currently taking any medication? YES NO
If "Yes," please list: _____
6. Do you have any known allergy to iodine, or have a history of asthma? YES NO
If "Yes," please list: _____
7. Have you ever had a reaction to a contrast medium ("dye") used during any MRI, CT, or X-ray examination? YES NO
8. Do you have diabetes or any disease(s) of your kidneys or blood? YES NO
If "Yes," please describe: _____

Female Patients:

11. Are you pregnant or experiencing a late menstrual period? YES NO
12. Are you currently breast feeding? YES NO

I attest that all the information provided is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to address any questions or concerns I have regarding the information on this form.

Signature of Person Completing Form: _____ Date: _____