Ft. Jesse Imaging Center

GALE KEERAN Center for Women

CT HISTORY FORM

Patient Name: _____

DOB: _____ Age: _____Height: _____ Current weight: _____

Have you had a previous imaging study related to this problem? □ **Yes** □ **No**

If yes. What exam? □ **CT** □ **MRI** □ **Ultrasound** □ **X-ray** □ **Other** What Facility? _____

PERSONAL HISTORY

Have you ever had a allergic reaction to injected CT or x-ray contrast (x-ray dye) □ **Yes** □ **No**

If yes, explain: _____

□ **Yes** □ **No** Heart Disease

□ **Yes** □ **No** High Blood Pressure

□ **Yes** □ **No** Asthma/Other Lung Disease

□ **Yes** □ **No** Kidney Disease/ Kidney Failure

□ **Yes** □ **No** Diabetes

□ **Yes** □ **No** Dialysis

□ **Yes** □ **No** Do you take Metformin hydrochloride (Glucophage, Glucovance, Avandement, Metaglip, or Fortamet?)

□ **Yes** □ **No** Allergies If yes, please specify: _____

□ **Yes** □ **No** Surgeries If yes, please specify: _____

□ **Yes** □ **No** Cancer If yes, please specify: _____

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding? □ **Yes** □ **No** Date of last period: _____

ACKNOWLEDGEMENT

I have answered these questions to the best of my knowledge and understand the information presented to me. If I am to have intravenous contrast with my procedure, I have been informed of the risks.

Patient/ Guardian Signature: _____ Date: _____

Technologists Signature: _____ Date: _____