



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

How many CT exams have you had in the last 12 months? _____

How many Cardiac Nuclear Medicine Studies have you had in the last 12 months? _____

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 Smoking

Yes No Allergies If yes, please specify: _____

Yes No Surgeries If yes, please specify: _____

Yes No Cancer If yes, please specify: _____

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

Yes No Have you ever had a allergic reaction to injected contrast (x-ray dye)
If yes, explain: _____

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: _____