SUMMIT radiology

CT Patient Questionnaire and Screening for CT Contrast Usage

Patient Name____ Date_________________________

Sex: M / F Age _____________ Date of Birth __________________

Do you have a return appointment scheduled with your doctor? Yes / No When: _____________

Have you had any previous studies / tests related to today's visit? Yes / No

If yes, please describe what studies / tests were done, what date the study / test was done ,and where it was d

____

Please describe any symptoms you have / or have had____

____

Do you have a history of cancer? Yes / No If yes, what type(s) and date(s) of cancer? _______________

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Are you pregnant or breastfeeding? Yes / No Do you smoke? Yes / No

Family History of Heart Disease? Yes / No Do you have hypertension? Yes / No

Please list any **Allergies** and what kind of reaction you have had:

Drugs/Perscriptions: ____

Food: ____

Any previous surgeries? Yes / No If yes, please list previous surgeries ____________________________

____

Do you have now or previously had:

Congestive Heart Failure	Yes / No
Heart Attack	Yes / No
Chest Pain	Yes / No
Asthma	Yes / No
Sickle Cell Disease	Yes / No
High BP / Low BP (please circle one)	Yes / No
Kidney Disease / Kidney Malfunction	Yes / No
Diabetic	Yes / No

If yes to Diabetes what medication do you take, if any? ______________________________

Have you EVER HAD an IV (Iodine) contrast for a radiologic prodedure? Yes / No

Have you ever been told you are allergic to Iodine / Xray dye / IV contrast ? Yes / No

I authorize the following diagnostic procedure to be performed and I understand that this is a diagnostic proce
that does have some remote risks and I consent to the treatment.

____ _________________________

Signature of Patient or Legal Representative Relationship to patient

* *

Technologist Data

GFR ___________________________________ Creatinine ___________________________

Comments____

Reaction Today: Yes / No Technologist_____________________

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