# CT History and Screening Form

| Last Name: | First Name: | Middle Init: | Date of Birth: |
|---|---|---|---|
| | | | |

Are You Pregnant? ☐Yes ☐No ☐N/A Last Menstrual Period: _____

Please explain your medical problem or reason why you visited your doctor:
Where is the problem? _____
What is the problem? _____
How long have you had this problem? _____

Have you had a previous exam related to this problem? ☐Yes ☐No What type of exam? _____
If Yes, When was the exam? _____ Where was the exam done? _____

List previous related surgeries: _____
Medications presently taking: _____

**CONTRAST HISTORY:**
Are you taking Glucaphage? ☐Yes ☐No
If yes, discontinue the day of the exam and for 48 hours after the exam.

HAVE YOU EVER HAD A PREVIOUS ALLERGIC REACTION OF X-RAY CONTRAST (DYE)? ☐Yes ☐No
If Yes, Have you been pre-medicated for this exam? ☐Yes ☐No

List any Drug or Food Allergies: _____

**PERSONAL HISTORY:**

| | | | | | |
|---|---|---|---|---|---|
| ☐Yes | ☐No | Asthma | ☐Yes | ☐No | Dizziness |
| ☐Yes | ☐No | Allergic Respiratory Disease | ☐Yes | ☐No | Heart Disease |
| ☐Yes | ☐No | Diabetes | ☐Yes | ☐No | Stroke |
| ☐Yes | ☐No | Diabetic Nephropathy | ☐Yes | ☐No | Cardiomyopthy |
| ☐Yes | ☐No | High Blood Pressure | ☐Yes | ☐No | Anxiety |
| ☐Yes | ☐No | Kidney Disease/Renal Failure | ☐Yes | ☐No | Liver Disease |
| ☐Yes | ☐No | Cancer | ☐Yes | ☐No | Seizure Disorder |
| ☐Yes | ☐No | Multiple Myeloma | ☐Yes | ☐No | Bladder Disease |
| ☐Yes | ☐No | Prostate Problems | ☐Yes | ☐No | Headaches |
| ☐Yes | ☐No | Are you Breast Feeding at this time? | | | |

If yes, please explain: _____

I have answered the questions to the best of my knowledge and have informed the technologist that I am not pregnant at this time.

_____ _____ _____
Date Patient or Legal Guardian (please sign) Relationship