



For Office Use Only
Place Patient ID label here

Computed Tomography (CT) Clinical Information

Patient Name _____ O Female O Male
Body part to be scanned _____ Exam Date _____
Reason for exam _____

Please list all medications you are currently taking _____

Y N Have you had previously related studies (nuclear scan, x-ray, ultrasound, CT, MRI or PET)? If yes, please explain and bring studies to your appointment.
_____ Number of prior CT and Cardiac Nuclear Medicine (myocardial perfusion) studies within the past 12 months

Type of Exam	Where	When	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments _____

Y N Have you had any surgery or therapy? If yes, explain type and when _____

For female patients only: Date of last menstrual period _____

Y N Are you nursing? Y N Are you possibly pregnant? (If yes, notify technologist immediately.)

Patient signature: _____

CONTRAST QUESTIONNAIRE: Have you had, or do you have any of the following?

- | | | |
|---|---|---|
| <input type="radio"/> Y <input type="radio"/> N Previous reaction to contrast
(if yes, notify RN immediately) | <input type="radio"/> Y <input type="radio"/> N Hypertension | <input type="radio"/> Y <input type="radio"/> N Smoker |
| <input type="radio"/> Y <input type="radio"/> N Allergies | <input type="radio"/> Y <input type="radio"/> N Asthma | <input type="radio"/> Y <input type="radio"/> N Non-smoker |
| <input type="radio"/> Y <input type="radio"/> N Infectious diseases | <input type="radio"/> Y <input type="radio"/> N Diabetes mellitus | <input type="radio"/> Y <input type="radio"/> N Ex-Smoker |
| <input type="radio"/> Y <input type="radio"/> N History of heart disease
(arrhythmia, angina, congestive
heart failure, myocardial
infarction) | <input type="radio"/> Y <input type="radio"/> N Multiple myeloma | <input type="radio"/> Y <input type="radio"/> N Interleukin 2 (received within
the last 2 weeks) |
| | <input type="radio"/> Y <input type="radio"/> N Pheochromocytoma | <input type="radio"/> Y <input type="radio"/> N Interleukin 2 (expect to
receive treatment today or
tomorrow) |
| | <input type="radio"/> Y <input type="radio"/> N Renal failure | |
| | <input type="radio"/> Y <input type="radio"/> N Sickle cell disease | |

If yes to any of the above, please explain: _____

Technologist/RN: _____ Date: _____

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Contrast Lot # _____ Exp. Date _____ Injected by _____
Contrast Dose _____ IV Site _____ Time _____ DLP _____
Reaction _____