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Advanced Medical Imaging

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medimageks.com

CT SAFETY SCREENING & MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____
Date of Birth:_____

Because of the presence of radiation and the potential for use of a contrast agent (dye), we must have an accurate medical and surgical history. Please answer the questions below.

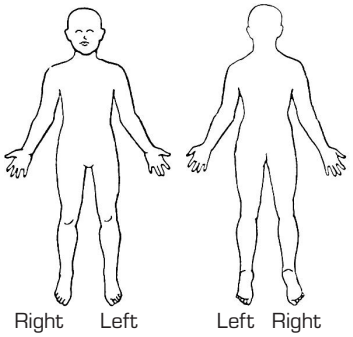
☐ Yes ☐ No Have you ever had an allergic reaction to CT contrast (dye)?
If yes, please describe your reaction and the treatment: _____
☐ Yes ☐ No Is there any possibility that you are pregnant?
☐ Yes ☐ No Are you diabetic? If yes, please list your medications: _____
☐ Yes ☐ No Do you have, or have you ever had, kidney disease? (this does not include kidney stones)
☐ Yes ☐ No Are you on chemotherapy? If yes, please list your medications: _____
☐ Yes ☐ No Have you received contrast within the last 72 hours?
☐ Yes ☐ No Do you have hypertension that requires medication?
☐ Yes ☐ No Do you have Multiple Myeloma?
☐ Yes ☐ No Are you taking hydroxyurea?

IF "YES " OR YOU ARE UNSURE ABOUT ANY OF THE ABOVE QUESTIONS , PLEASE TELL THE FRONT DESK STAFF IMMEDIATELY .

☐ Yes ☐ No Do you have asthma?
☐ Yes ☐ No Do you have any allergies, including medications?
If yes, list allergies: _____

What is your current weight? _____ (lbs/kgs) What is your height? _____
Reason your doctor ordered the exam? _____

☐ Yes ☐ No Are you currently having symptoms? If yes, for how long?_____
Please mark the location of your symptoms on the diagram. →



☐ Yes ☐ No Do you have pain? If yes, does your pain radiate (spread out)? _____
Where: _____
☐ Yes ☐ No Have you ever had cancer? When: _____ Type: _____
☐ Yes ☐ No Do you smoke, or have a history of smoking?
☐ Yes ☐ No Have you had an injury to the area we are scanning today?
When: _____ Describe injury: _____
☐ Yes ☐ No Have you had any surgeries to the area of your body we are scanning today?
When: _____ Describe surgeries: _____
☐ Yes ☐ No Have you had past imaging studies of the area of your body we are scanning today?
Type of study: _____ When: _____ Where: _____
Type of study: _____ When: _____ Where: _____

Other medical history we should know about? _____

Signature of patient: _____ Date: _____

Name of the person filling out this form, if other than the patient (please print): _____

Relationship to the patient (please print): _____

Technologist Initials: _____