



Exam Date: \_\_\_\_\_

X-Ray #: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Why did your doctor order this CT? \_\_\_\_\_

Have you had a previous CT?  No  Yes If yes, when & where was it done? \_\_\_\_\_

Have you ever had cancer?  No  Yes If Yes, what kind? \_\_\_\_\_

Was it treated by: Surgery:  No  Yes When? \_\_\_\_\_  
 Chemo:  No  Yes When? \_\_\_\_\_  
 Radiation:  No  Yes When? \_\_\_\_\_  
 Other:  No  Yes When? \_\_\_\_\_

Please list any other major illnesses or diseases you may have had: \_\_\_\_\_

Have you ever had any surgery?  No  Yes If yes, what kind and when was it done? \_\_\_\_\_

Are you allergic to: **Iodine** (or x-ray dye?):  No  Yes \_\_\_\_\_  
**Latex?**  No  Yes \_\_\_\_\_  
**Shellfish?**  No  Yes \_\_\_\_\_

Please list any other food or drug allergies you may have: \_\_\_\_\_

Do you have: **Asthma:**  No  Yes If yes: Are you on inhalers?  No  Yes  
**Emphysema:**  No  Yes  
**Kidney Problems:**  No  Yes  
**Heart Disease:**  No  Yes  
**Diabetes:**  No  Yes If yes: Do you use insulin?  No  Yes  
 Do you take glucophage?  No  Yes

Please list any other medications you are taking? \_\_\_\_\_

**Females:** Is there any chance that you may be pregnant or are you trying to conceive?  No  Yes

Date of last menstrual cycle: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Technologist Use:	Contrast Agents:	
	Oral:	
	I.V.:	
	Creatinine:	
	B.P.:	Pulse: