CT History Form

Imaging Specialists

PATIENT NAME: _____ **DATE:** _____

1. **TRAUMA:** ☐ Y / ☐ N **WHERE?** _____

2. HISTORY/DIAGNOSIS: Why was the exam ordered? _____

_____

_____

3. Allergies/Asthma/Anaphylactic Reaction? ☐ **Y** / ☐ **N** _____

_____

4. Previous Reaction to CT/X-ray Dye (Contrast): _____

5. Prior Surgeries (Check all that apply): ☐ **NONE**

☐AAA ☐Brain ☐Lung ☐Heart ☐Breast ☐Cervical ☐Carotid

☐Lumbar ☐Tubal ☐Hernia ☐Bladder ☐Sinus ☐Hysterectomy

☐Kidney ☐Prostate ☐Small Bowel ☐Large Bowl ☐Tonsillectomy

☐Appendectomy ☐Gallbladder ☐Pacemaker ☐Defibrillator ☐Bariatric Surgery

Other: _____

6. Are you pregnant? ☐Y/☐N Last Menstrual cycle __/__/__

7. How many CTs have you had in the last year? _____

8. History of Cancer? ☐Y/☐N Type? _____

9. Have you had Chemotherapy? ☐Y/☐N Radiation? ☐Y/☐N

10. Smoking status: ☐ Current smoker ☐Former smoker ☐Never smoked

11. Kidney Problems? ☐Y/☐N Requiring Dialysis? ☐Y/☐N

12. Diabetes? ☐Y/☐N ☐oral medication ☐insulin

Technologist section

Creatinine: _____ GFR: _____ Contrast type: **Isovue 370** Route: **IV** Amount: _____ ml

Tech Preforming exam: _____ Date: _____