CT Scan History Form

FOR OFFICE USE ONLY	
Oral Contrast:	Water / Gastroview
IV Contrast:	Omni/Visi (_____ cc.)
iSTAT / Lab	_____ Creatinine _____Date
IV gauge:	_____ / Site _____ / Initials _____
Power Picc/Power Port _____Flush After Exam	
Premedicated	☐ Yes ☐ No
Reaction to Iodine	☐ Yes ☐ No

Name: _____

Date: _____ Height:_____ Weight:_____ Age: ____

Today's Exam(s): _____

1. **Are you allergic to IV Contrast (Dye)? ☐Yes ☐No**
2. Have you ever been diagnosed with multiple myeloma?

   ☐ Yes ☐ No
3. Please describe your current symptoms: _____

   _____
4. How long have you had these symptoms: _____
5. Have you ever had any type of surgery in the area(s) to be scanned today? ☐ Yes ☐ No

   If yes, list dates and types: _____
6. Have you ever had any type of cancer? ☐ Yes ☐ No

   If yes, list dates and types: _____

   If yes, have you had the following? ☐ Radiation ☐ Chemo Therapy
7. Have you had any vascular surgery or stents? ☐ Yes ☐ No

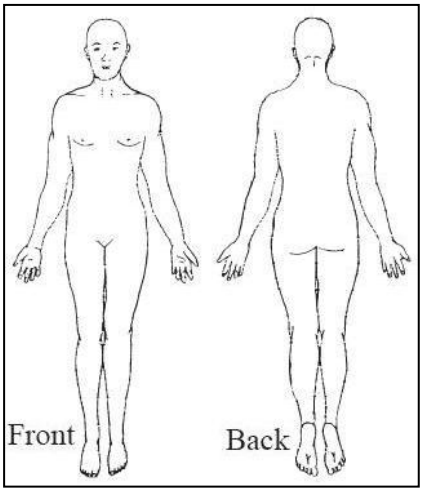
   If yes, list dates and types: _____
8. Are you Diabetic? ☐ Yes ☐ No If yes, how long? _____
9. Do you take Glucophage or Metformin? ☐ Yes ☐ No

   Patient was given Glucophage/Metformin Info Sheet _____
10. Do you have any kidney problems you are aware of? ☐ Yes ☐ No

    If yes what type(s): _____
11. Do you have 2 kidneys? ☐ Yes ☐ No
12. Do you have any allergies? ☐ Yes ☐ No

    If yes, please list: _____
13. Have you had any previous CAT Scan, MRI Scan or Ultrasounds related to the test you are having today? ☐ Yes ☐ No

    If yes where/when: _____



Please indicate where you are having pain/symptoms on the diagram.

Patient Signature: _____