

Name: _____

1. Have you had any surgery? YES NO
Please list: _____

2. Have you ever had a diagnosis of cancer? YES NO
If yes, what kind and when was the diagnosis made? _____
Did you have Radiation therapy? _____
Chemotherapy? _____

3. Are you allergic to any medications? YES NO
Please list: _____

4. **Please circle symptoms that pertain to your exam today:**

Diabetic	Headache	Frequent Urination
Pain	Blurred Vision	Blood in Urine/ Stool
Kidney Problems	Dizziness	Constipation
Swelling	Nausea/Vomiting	Smoker
Fever	Diarrhea	Appetite Loss
Unable to urinate	Weight loss	Cough / Cough up Blood
Injury to area of question		

5. Have you had any previous CT's? YES NO
Where: _____
6. Have you had any previous labs drawn in the last 4 months and if so where? _____
7. Please describe why you are having this exam: _____

Contrast Consent

A contrast agent has been developed to produce better pictures of your body that is being examined. This contrast agent will be injected into your vein. In a small percentage of cases headaches or nausea are noted up to 24 hours following contrast administration. In a smaller percentage of cases, there may be more severe complications. These problems are usually recognized promptly and treated without difficulty. If there is any history of anemia, sickle cell anemia, or kidney disorder, these should be described to the technologist and radiologist.

Female Patients: If you are pregnant or breast feeding, please notify the technologist.

I consent and authorize **Advanced Imaging** to perform a contrast injection for an CT scan on me.

Signed: _____ Date: ____/____/____

TECHNOLOGIST SECTION

History of previous reaction to IV contrast YES NO

Diabetic/ Kidneys:

Diabetic YES NO
Currently taking Glucophage, Metformin,
Metaglip, Advandament, or Glucovance

BUN: _____
CREAT: _____

Patient given home instructions:
YES NO

CONTRAST / AMOUNT:
