NETWORK radiology
P: 216.291.8480 - F: 216.291.8490

CT SCAN PRE-SCREENING / HISTORY FORM

NAME _____ D.O.B._____ MALE / FEMALE

CT EXAM_____ WITH I.V. CONTRAST? YES / NO

ORDERING DOCTOR_____ HEIGHT_____ WEIGHT_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK BOX NO OR YES.

CONDITION	NO	YES	IF YES:
PRIOR ALLERGIC REACTION TO CT, X-RAY, ANGIOGRAPHY OR HEART CATHETERIZATION CONTRAST OR "DYE" (ANY 'ITCHING', 'REDNESS')			I.V. CONTRAST CANNOT BE INJECTED WITHOUT PRE-MEDICATED UNDER YOUR DOCTOR'S DIRECTION
ALLERGY TO ANY FOOD OR MEDICATION			LIST ALL ALLERGIES:
MULTIPLE MYELOMA			I.V. CONTRAST CANNOT BE INJECTED
KIDNEY DISEASE (NOT STONES), IMPAIRED KIDNEY FUNCTION OR DIALYSIS			
THYROID DISEASE			
SICKLE CELL CONDITION			I.V. CONTRAST CANNOT BE INJECTED
DIABETES			LIST YOUR DIABETIC MEDICATIONS:
ASTHMA OR COPD			
ANY BLOOD DISORDER (INCLUDING HIV AND HEPATITIS)			
PRIOR SURGERY IN THE AREA BEING SCANNED			

CONDITION	NO	YES
CANCER		

IF YES, LIST TYPE:

DATE OF LAST CHEMO:

____/____/____

DATE OF LAST RADIATION:

____/____/____

FEMALE PATIENTS: IS THERE ANY POSSIBILITY THAT YOU ARE PREGNANT? YES / NO FIRST DATE OF LAST MENSTRUAL PERIOD ____/____/____

IF UNSURE, A PREGNANCY TEST MUST BE ORDERED BY YOUR PHYSICIAN AND THE RESULTS SENT TO US BEFORE EXAM.

IF YOU ARE PREGNANT, WE MUST HAVE WRITTEN CLEARANCE FROM YOUR OB/GYN AND FROM OUR RADIOLOGIST BEFORE WE CAN DO YOUR EXAM.

~NURSING MOTHERS SHOULD DISCARD BREAST MILK FOR 24 HOURS AFTER INJECTION OF I.V. CONTRAST~

REASON FOR SCAN / PT HISTORY (OFFICE USE ONLY)

DATE

PATIENT SIGNATURE

PATIENT'S REPRESENTATIVE SIGNATURE

RELATIONSHIP: ____PARENT (MINOR UNDER 18 YRS)

____COURT APPOINTED GUARDIAN

TECHNICIAN REVIEW & SIGNATURE