Date: _____ Time: _____

Reason for Exam: _____

List all surgeries: _____

Prior exams: _____

List all existing medical problems: _____

_____

List all medications: _____

_____

Are you a Diabetic: ☐ Yes ☐ No. Do you take Glucophage: ☐ Yes ☐ No

Do you have a history of:

Allergies (x ray dye, latex, medications) ☐ No ☐ Yes If yes, _____

Have you every had an Iodine Injection: ☐ No ☐ Yes If yes, _____

Do you have a history of:

Cancer: ☐ No ☐ Yes If yes, _____

Lung Disease: ☐ No ☐ Yes If yes, _____

Heart Disease: ☐ No ☐ Yes If yes, _____

Blood Disorder: ☐ No ☐ Yes If yes, _____

Kidney Disease: ☐ No ☐ Yes If yes, _____

Are you taking a blood thinner currently: ☐ No ☐ Yes If yes, _____

Date of last renal function labs: _____ BUN _____(5-21) Creatinine _____(0.7-1.5)

Are you possibly pregnant: ☐ No ☐ Yes If yes, _____

Type of IV contrast used: _____ Amount: _____

Lot # _____ Expiration Date: _____

Patient Signature: _____ Date: _____ Time: _____

Technologist Signature: _____ Date: _____ Time: _____

SOUTHERN SURGICAL HOSPITAL

SSH-RAD013 2/11

CT AND/OR IV CONTRAST SCREENING

Patient Label