

CAT SCAN & IVP FORM

DATE		MRN#		PATIENT WEIGHT	
PATIENT NAME:			DOB:		
/PHYSICAN ORDERING EXAM:					

DO YOU HAVE A HISTORY OF THE FOLLOWING? (Please circle)

ASTHMA	YES	NO	SICKLE CELL ANEMIA	YES	NO
HEART DISEASE	YES	NO	SHORTNESS OF BREATH	YES	NO
PULMONARY DISEASE	YES	NO	HIGH BLOOD PRESSURE	YES	NO
RENAL DISEASE	YES	NO	LIVER DISEASE	YES	NO
MULTIPLE MYELOMA	YES	NO	DEBILITATED	YES	NO
BLOOD IN URINE	YES	NO	KIDNEY STONES	YES	NO
DIABETES	YES	NO			

ALLERGY HISTORY: Do you have any drug, food, or environmental allergies: yes no
If yes, of what? _____

If you are diabetic are you on any of the following medications?
(On Glucophage/Glugovance//Metaglip/Metformin) Yes No
If you answered yes to Diabetes have you taken any of the above listed medications within
The last 24 hours? Yes No

*****FOR TECHNOLOGIST USE ONLY*****
<i>Patient History :</i>
<i>Patient reason for exam:</i>
Time patient last ate _____ Oral contrast _____ Creatinine level: _____ Date: _____ Contrast type: _____ Amount given _____ Injected by _____ Any Reaction _____

History of Cancer Yes ___ or No ___
Location of Cancer: _____

Have you ever had Chemo therapy? Yes ___ or No ___ Last Treatment /body part _____

Have you ever had Radiation Therapy? Yes ___ or No ___ Last treatment /body part _____

Females Only
Date of last Menstrual Period _____ Is there a possibility of pregnancy? Yes ___ or No ___ Breastfeeding: Yes ___ or No ___ (If having IV contrast you may want to express and dispose of breast milk for the next 24 hours)

Have you ever had a Cat Scan or IVP? Yes ___ or No ___
If so where and when: _____ Body part scanned _____

TECH INITIAL: _____
Did you experience any reaction from the IV contrast? Yes ___ or No ___

If yes explain: _____

Please list any major surgeries you may have had: _____