



CT / IVP
PATIENT HISTORY / SCREENING

ADDITIONAL EXAMS \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_

OFFICE USE ONLY BUN: \_\_\_\_\_ CREATININE: \_\_\_\_\_ DATE DRAWN: \_\_\_\_\_

PLEASE COMPLETE ALL QUESTIONS

Have you ever had surgery relating to any of these areas? (If yes, please briefly explain in the area provided)

- 1. Head [ ] Yes [ ] No 5. Pelvis [ ] Yes [ ] No
2. Neck [ ] Yes [ ] No 6. Spine [ ] Yes [ ] No
3. Chest [ ] Yes [ ] No 7. Other [ ] Yes [ ] No
4. Abdomen (stomach) [ ] Yes [ ] No

Type of Surgery: \_\_\_\_\_

Have you ever been diagnosed with any of the following?

- 1. Heart disease [ ] Yes [ ] No 3. Kidney problems [ ] Yes [ ] No
2. Diabetes [ ] Yes [ ] No 4. Cancer [ ] Yes [ ] No

Have you ever been injected with x-ray dye for any of the following procedures?

- 1. IVP [ ] Yes [ ] No 4. Arteriogram [ ] Yes [ ] No
2. CT Scan [ ] Yes [ ] No 5. Heart Cath [ ] Yes [ ] No
3. Venogram [ ] Yes [ ] No

Is there any possibility that you may be pregnant? [ ] Yes [ ] No Last menstrual period? \_\_\_\_\_

Are you allergic to any medicines that you are aware of? [ ] Yes [ ] No

If yes, what type? \_\_\_\_\_

Have you ever had a CAT Scan or bone scan before? [ ] Yes [ ] No

If so, where? \_\_\_\_\_

Are you currently undergoing radiation treatments? [ ] Yes [ ] No Physician: \_\_\_\_\_

Have you ever had any radiation treatments? [ ] Yes [ ] No

If so, what area of the body? \_\_\_\_\_

If you are diabetic, do you take: [ ] metformin [ ] Glucophage [ ] avandamet [ ] glucovance [ ] metaglip

Do you have asthma? [ ] Yes [ ] No