RIVER OAKS
MRI & DIAGNOSTIC

CT Patient History/Screening Form

Print Patient Name: _____DOB: _____
Referring Physician:_____
Primary Care Physician:_____

Pregnancy Release

To the best of your knowledge are you pregnant? _____Yes _____No
Date of Last Menstrual:_____
Hysterectomy ____Yes ____No Tubal ligation _____Yes _____No
I am aware that having an X-ray or CT exam while pregnant could be harmful to an unborn baby. It is my understanding that protective shielding will be used when applicable and hereby give my consent to perform the X-Ray / CT Scan which my physician has prescribed
Patient/guardian signature_____

To help us perform the best exam for you, please answer the following questions about your medical history

Height	Weight

What symptoms do you have relating to today's exam and how long have you had them?
_____
_____

List any surgeries you have had relating to today's exam (Date-type of surgery)
_____
_____

Yes	No	Are your allergic to any medications? If yes, to what:_____
Yes	No	Are you allergic to any foods or other substances? If yes, to what:_____
Yes Yes	No No	Have you ever had an injection of contrast dye for a CT scan or kidney x-rays? Did you experience a rash, hives, or difficulty breathing following the injection?
Yes	No	Do you have asthma?
Yes* Yes	No No	Are you diabetic? Do you take medication for your diabetes? What medication:_____
Yes*	No	Do you take medication for High Blood Pressure?
Yes	No*	Do you have both kidneys?
Yes*	No	Have you ever had kidney surgery/ If yes, when_____ for what reason :_____
Yes*	No	Have you ever had been told you have decreased kidney function?
Yes	No	Are you on dialysis?
Yes Yes Yes	No No No	Have you ever been diagnosed with cancer? What kind of cancer?_____ When were you diagnosed?_____ Did you have chemotherapy? When was last treatment:_____ Did you have Radiation? When was last treatment? _____
Yes	No	Are you breastfeeding?

**Any answer with an asterisk requires a creatinine prior to contrast administration*

Patient/Guardian Signature_____Date_____

OFFICE USE ONLY

Creatinine: _____ GFR(mL/min): _____ Contrast order verified: ____Yes ____No
Contrast used: _____ Contrast amount: _____
IV Location: _____ Inserted by: _____
Expiration Date: _____ Lot # _____Extravasations: _____Yes _____No
Tech Notes: _____
_____