

**INSTRUCTIONS: Please complete this patient history form to the best of your ability. If there is a possibility that you may be pregnant, do not continue but inform the Technologist now.**

Your Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

History (The reason why you are having this exam): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**For each of the following questions, please check Yes or No:**

Do you have a known allergy to X-ray Contrast? (X-ray dye or iodine).....  YES  NO

Have you had any exams requiring IV or Oral contrast (X-ray dye) within the past week?.....  YES  NO

Do you have any Kidney Problems?.....  YES  NO

Is there a possibility that you may be pregnant?.....  YES  NO

Are you currently breast-feeding?.....  YES  NO

Do you have diabetes? .....  YES  NO

Are you taking **Glucophage/Metformin**? .....  YES  NO

Do you have a known heart problem, Heart Failure, or Angina?.....  YES  NO

Do you have/or have you had Cancer? .....  YES  NO

If Yes, what type? \_\_\_\_\_

Have you had any previous surgeries? .....  YES  NO

If Yes, please list: \_\_\_\_\_

Are you having this exam because of a recent or past injury (Trauma)?.....  YES  NO

If yes, what was injured? \_\_\_\_\_

When was the injury? \_\_\_\_\_

Have you had a prior CT Scan? .....  YES  NO

If yes, what was it of? \_\_\_\_\_

If yes, where was it done? \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

**(This Section for Staff Use Only) Contrast and Technologist Information: (Required)**

Contrast Agent: \_\_\_\_\_ Volume Injected (mL) \_\_\_\_\_

Tech: \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_ Tech: \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_

Signature Date Time Signature Date Time

Post-procedure Metformin instructions given if indicated.

Orders are clear, correct, pertinent to study ordered, and billable  Patient consent form has been signed

Contrast Information is complete

Post-procedure Patient Condition:  Good  Complication, (explain): \_\_\_\_\_

**NOTE: If the Patient Has a Reaction, Fill Out a Contrast Reaction Form**

**Imaging Services Patient History and Contrast Worksheet**

MNM 721.159



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