DESOTOIMAGING
SPECIALISTS

Date: _____

CT HISTORY FORM

Patient Name: _____ MRN# _____ DOB: _____

Age: _____ Weight: _____ Height: _____ M/F: _____ Ordering Physician: _____

Have you had a previous imaging study related to this problem? YES _____ NO _____

If yes, What exam? CT _____ MRI _____ Ultrasound _____ X-Ray _____ Other _____

What facility? _____

Personal History

How many CT exams have you had in the last 12 months? _____

How many Cardiac Nuclear Medicine Studies have you had in the last 12 months? _____

Yes ___ No ___ Heart Disease Yes ___ No ___ Asthma/Other Lung Disease

Yes ___ No ___ Diabetes Yes ___ No ___ Kidney Disease/Kidney Failure

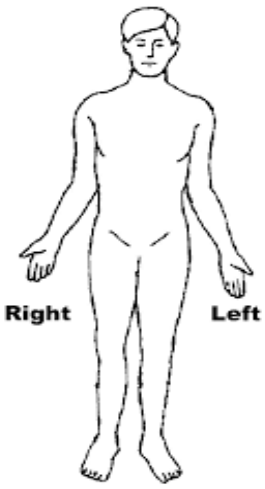
Yes ___ No ___ Smoking Yes ___ No___ Dialysis

Yes ___ No ___ Covid 19 Vaccine Date: _____

Yes ___ No ___ Allergies Please specify: _____

Yes ___ No ___ Cancer Please specify: _____

Yes ___ No ___ Pregnant Yes ___ No ___ Breast Feeding



Yes ___ No ___ Have you ever had an allergic reaction to IV contrast (X-ray dye/iodine)?

If yes, what was your reaction: _____

Surgeries: _____

Female Patients Only

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Date of last period: _____

ACKNOWLEDGEMENT

I have answered these questions to the best of my knowledge and understand the information presented to me. If I am to have intravenous contrast with my procedure, I have been informed of the risks.

Patient/ Guardian Signature: _____ Date: _____

Technologist Signature: _____ Date: _____

*****For Internal use***** **Contrast Administration**

Volume/Name: _____cc of _____ Lot # _____ Exp. Date _____

IV Information: Size _____ Location _____ R/L # of attempts _____ Infiltration: ____ Yes ____ No Amount: _____cc

Comments: _____