

ImageCare

Patient History

Name: _____ Date of Birth: _____ Date: _____ Ht. ___ Wt. ___

Please describe your current symptoms in detail (include duration):

Have you ever had a CT? NO YES

Have you ever had IV Contrast? NO YES

Have you ever had a reaction to IV contrast? NO YES

If YES, please explain: _____

Please list any known allergies: _____

Please list all current medications: _____

Please list all previous surgeries: _____

Do you have a history of: (Please circle YES or NO)

High Blood Pressure	Y	N	Tuberculosis	Y	N
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Heart Problems	Y	N	Hepatitis	Y	N
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Asthma	Y	N	Pheochromocytoma	Y	N
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Lung Problems	Y	N	Sickle Cell Disease	Y	N
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Do you use an inhaler	Y	N	Diabetes	Y	N
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Kidney Problems	Y	N	Glucophage/Metformin	Y	N
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Personal history of cancer	Y	N	Chemotherapy	Y	N
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Radiation Therapy	Y	N			
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Are you pregnant?	Y	N	Are you breastfeeding?	Y	N
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Other previous or related testing: _____

Is this an injury related illness: Y N Date of Accident: _____

Patient: _____ Signature _____
Technologist: _____ Signature _____

Tech notes _____

Contrast Dose: _____ (Name, Dosage and Vial Size) Pacs list ___ Nuance ___ MDM ___