ImageCare Patient History

Please describe your current symptoms in detail (include duration): Have you ever had a CT? NO YES Have you ever had a reaction to 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: NO YES Have you ever had a CT? NO YES If YES, please explain: Please list any known allergies: Please list any known allergies: Please list any known allergies: Please circle YES or NO) High Blood Pressure Y N Tuberculosis Y N Hepatitis Y N Hepatitis Y N Pheochromocytoma Y N N Hepatitis Y N Pheochromocytoma Y N N Sickle Cell Disease Y N N Diabetes Y N N Diabetes Y N N Glucophage/Metformin Y N N Glucophage/Metformin Y N N Personal history of cancer Y N Chemotherapy Y N Radiation Therapy Y N Are you breastfeeding? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient: Signature Technologist: Signature Technologist: Signature Technologist: Signature Technologist:	Name:			Date of	Birth: Date:		Ht	_Wt
Have you ever had IV Contrast? 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: NO YES HYES, please explain: Please list any known allergies: NO YES NO YES NO YES NO YES HAVE PLEAS RY N Please circle YES or NO) High Blood Pressure Y N Hepatitis Y N Hepatitis Y N Hepatitis Y N Pheochromocytoma Y N Lung Problems Y N Sickle Cell Disease Y N Diabetes Y N Glucophage/Metformin Y N Personal history of cancer Y N Chemotherapy Y N Are you breastfeeding? Y N Other previous or related testing: Please circle YES or NO) High Blood Pressure Y N Dabetes Y N Diabetes Y N Are you breastfeeding? Y N Other previous or related testing: Please circle YES or NO) High Blood Pressure Y N Dabetes Y N Diabetes Y N Are you breastfeeding? Y N Other previous or related testing:	Please describe your current s	symptoms in	n detail (inc	lude duratio	n):			
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: Please list any known allergies: Please list all previous surgeries: Please list all previous surge	Have you ever had a CT?			NO	YES			
Please list any known allergies: Please list all current medications: Please list all previous surgeries: Please list all current medications: Please list	Have you ever had IV Contrast?			NO	YES			
Please list any known allergies: Please list all current medications: Please list all previous surgeries: Do you have a history of: High Blood Pressure Y N Tuberculosis Y N Heart Problems Y N Hepatitis Y N Asthma Y N Pheochromocytoma Y N Lung Problems Y N Diabetes Y N Glucophage/Metformin Y N Personal history of cancer Y N Glucophage/Metformin Y N Are you pregnant? Y N Other previous or related testing: Signature Technologist: Technologist: Signature	Have you ever had a reaction to IV contrast?			NO	YES			
Please list all current medications: Please list all previous surgeries: Do you have a history of: High Blood Pressure Y N Tuberculosis Y N Heart Problems Y N Hepatitis Y N Asthma Y N Pheochromocytoma Y N Lung Problems Y N Sickle Cell Disease Y N Do you use an inhaler Y N Diabetes Y N Kidney Problems Y N Glucophage/Metformin Y N Personal history of cancer Y N Chemotherapy Y N Radiation Therapy Y N Are you pregnant? Y N Are you breastfeeding? Y N Other previous or related testing: Technologist: Technologist: Technologist: Signature	If YES, please expla	ain:						
Please list all previous surgeries: Do you have a history of:	Please list any known allers	gies:						
Do you have a history of: High Blood Pressure Y N Tuberculosis Y N Heart Problems Y N Heart Problems Y N Asthma Y N Pheochromocytoma Y N Lung Problems Y N Sickle Cell Disease Y N Kidney Problems Y N Glucophage/Metformin Y N Personal history of cancer Y N Chemotherapy Y N Are you pregnant? Y N Other previous or related testing: Signature Technologist: Signature Signa	Please list all current medic	cations:						
Do you have a history of: High Blood Pressure Y N Tuberculosis Y N Heart Problems Y N Hepatitis Y N Asthma Y N Pheochromocytoma Y N Lung Problems Y N Sickle Cell Disease Y N Do you use an inhaler Y N Diabetes Y N Kidney Problems Y N Glucophage/Metformin Y N Personal history of cancer Y N Chemotherapy Y N Radiation Therapy Y N Are you pregnant? Y N Are you breastfeeding? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient:								
High Blood Pressure Y N Tuberculosis Y N Heart Problems Y N Hepatitis Y N Asthma Y N Pheochromocytoma Y N Lung Problems Y N Sickle Cell Disease Y N Do you use an inhaler Y N Diabetes Y N Kidney Problems Y N Glucophage/Metformin Y N Personal history of cancer Y N Chemotherapy Y N Radiation Therapy Y N Are you pregnant? Y N Are you breastfeeding? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient:	Please list all previous surg	geries:						
Heart Problems Y N Hepatitis Y N Asthma Y N Pheochromocytoma Y N Lung Problems Y N Sickle Cell Disease Y N Do you use an inhaler Y N Diabetes Y N Kidney Problems Y N Glucophage/Metformin Y N Personal history of cancer Y N Chemotherapy Y N Radiation Therapy Y N Are you pregnant? Y N Are you breastfeeding? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient: Technologist: Signature	Do you have a history of:		(Please cir	cle YES or	NO)			
Asthma Y N Pheochromocytoma Y N Lung Problems Y N Sickle Cell Disease Y N Do you use an inhaler Y N Diabetes Y N Kidney Problems Y N Glucophage/Metformin Y N Personal history of cancer Y N Chemotherapy Y N Radiation Therapy Y N Are you pregnant? Y N Are you breastfeeding? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient:	High Blood Pressure	Y	N		Tuberculosis	Y	N	
Lung Problems Y N Sickle Cell Disease Y N Do you use an inhaler Y N Diabetes Y N Kidney Problems Y N Glucophage/Metformin Y N Personal history of cancer Y N Chemotherapy Y N Radiation Therapy Y N Are you pregnant? Y N Are you breastfeeding? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient:	Heart Problems	Y	N		Hepatitis	Y	N	
Do you use an inhaler Y N Diabetes Y N Kidney Problems Y N Glucophage/Metformin Y N Personal history of cancer Y N Chemotherapy Y N Radiation Therapy Y N Are you pregnant? Y N Are you breastfeeding? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient:	Asthma	Y	N		Pheochromocytoma	Y	N	
Kidney Problems Y N Glucophage/Metformin Y N Personal history of cancer Y N Chemotherapy Y N Radiation Therapy Y N Are you pregnant? Y N Are you breastfeeding? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient:	Lung Problems	Y	N		Sickle Cell Disease	Y	N	
Personal history of cancer Y N Chemotherapy Y N Radiation Therapy Y N Are you pregnant? Y N Are you breastfeeding? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient: Signature Technologist: Signature	Do you use an inhaler	Y	N		Diabetes	Y	N	
Radiation Therapy Y N Are you pregnant? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient: Signature Technologist: Signature	Kidney Problems	Y	N		Glucophage/Metformin	Y	N	
Are you pregnant? Y N Are you breastfeeding? Y N Other previous or related testing: Is this an injury related illness: Y N Date of Accident: Patient: Signature Technologist: Signature	Personal history of cancer	Y	N		Chemotherapy	Y	N	
Other previous or related testing: Is this an injury related illness: Patient: Signature Technologist: Signature	Radiation Therapy	Y	N					
Is this an injury related illness: Y N Date of Accident: Patient: Technologist: Signature	Are you pregnant?	Y	N		Are you breastfeeding?	Y	N	
Patient:Technologist:Signature	Other previous or related testi	ing:						
Patient:Technologist:Signature								
	Is this an injury related illne	ess:	Y N	Date o	f Accident:			
	Patient:			Tec	hnologist:			
Tech notes	_					-		
	Tech notes							