NEUROSKELETAL IMAGING

Date of Birth:

Referring Physician: Accession #:

CT Scanning Patient History

☐ Yes ☐ No Are you diabetic?

☐ Yes ☐ No Do you take glucophage/metformin/glucovance?

☐ Yes ☐ No Do you or have you ever had cancer?

☐ Yes ☐ No Is there a possibility that you might be pregnant?

☐ Yes ☐ No History of kidney failure?

☐ Yes ☐ No History of heart disease?

☐ Yes ☐ No Severe debilitation?

☐ Yes ☐ No History of sickle cell anemia?

☐ Yes ☐ No History of asthma?

☐ Yes ☐ No History of hay fever?

☐ Yes ☐ No History of unstable angina?

☐ Yes ☐ No History of recent heart attack?

☐ Yes ☐ No History of pulmonary hypertension?

☐ Yes ☐ No Have you ever had x-ray contrast?

☐ Yes ☐ No Any reaction to x-ray contrast?

☐ Yes ☐ No Breast feeding?

History of severe arrhythmias such as:

☐ Yes ☐ No Ventricular tachycardia

☐ Yes ☐ No Sinoarterial dysfunction

☐ Yes ☐ No Heart block second or third degree

Symptoms and duration _____

Any allergies to medication or foods? _____

Please list any surgeries you have had: _____

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (Parent or Guardian) _____

Date Signed: _____