Colorado Canyons Hospital & Medical Center
CT Patient History

Exam Date: MRN:

Patient Name: Ordering Physician:

Patient to complete questions below:

1. What problem(s) brought you to the doctor that resulted in this exam being ordered?

2. Have you had any prior imaging studies (X-Ray, MRI, CT, Ultrasound, etc.)? ☐ Yes ☐ No
   If yes, when and where?

3. Are you allergic to any medications? ☐ Yes ☐ No
   If yes, please list:

4. Have you ever been given x-ray dye/contrast? ☐ Yes ☐ No
   If yes, did you develop an allergic reaction to the contrast? ☐ Yes ☐ No
   If yes, have you been pre-medicated for this exam overnight? ☐ Yes ☐ No

5. If female, is there any chance of pregnancy? ☐ Yes ☐ No
   Date of Last Menstrual Period: Are you breast feeding? ☐ Yes ☐ No

6. Do you have any of the following conditions?
   - Multiple Myeloma ☐ Yes ☐ No
   - Sickle Cell Anemia ☐ Yes ☐ No
   - Pheochromocytoma ☐ Yes ☐ No
   - Renal Failure / Kidney Problems ☐ Yes ☐ No
   - Are you on Dialysis? ☐ Yes ☐ No
     If yes, when do you dialyze next?

7. Have you had surgery in area we are scanning today? ☐ Yes ☐ No
   If yes, type of surgery and dates: _____

8. Have you ever been diagnosed with cancer? ☐ Yes ☐ No
   If yes, type of cancer and dates: _____
   If yes, treatment received? ☐ Chemo Therapy ☐ Radiation

9. Are you diabetic? ☐ Yes ☐ No
   If yes and you are taking any of the following medications for your Diabetes, please circle all that apply:
   Metformin, Glucophage, Glucovance, ActosPlus, Avandamet, Janumet, Metaglip, Fortamet, Glumetza, jentadueto, Tragenta

10. What is your current weight? Height?

For department use only:

BUN: CREATININE: GFR:

Contrast: ☐ Isovue 300 ☐ Isovue 370 Lot #: _____Exp. Date:_____

Amount: _____ml's IV Size: _____ Site: _____ ml/Sec: _____

Tech:

Contrast Reaction: ☐ Yes ☐ No If yes, Please explain: