MedCross Imaging LLC

CT Screening Form

Date_____

Last Name _____ **First Name**_____

DOB_____ **Age**_____ **Height**_____ **Weight**_____ (lbs) **Male / Female**

Please describe your symptoms/injury or reason for procedure? _____

_____

_____

How long have you had these symptoms? _____

Are you taking any of the following medications (Please check)?

□ Glucophage	□ Metformin	□ Metaglip	□ Actoplus Met	□ Riomet	□ Janumet
□ Glucophage XR	□ Glucovance	□ Fortamet	□ Avandamet	□ Glumetza	_____

If you marked any of the medications listed above, AND you are receiving IV contrast (dye) today, you must discontinue taking these medications for 48 hours after your CT exam.

MEDICAL HISTORY SCREENING – PLEASE ANSWER THE FOLLOWING(Yes or No)

Asthma	□ Yes □ No	Headaches or Dizziness	□ Yes □ No
Allergic Respiratory Disease	□ Yes □ No	Heart Disease	□ Yes □ No
Diabetes	□ Yes □ No	Stroke	□ Yes □ No
Kidney Disease/Renal Failure	□ Yes □ No	Multiple Myeloma	□ Yes □ No
Liver Disease	□ Yes □ No	Seizure Disorder	□ Yes □ No
Bladder Disease	□ Yes □ No	Any Chance of Pregnancy	□ Yes □ No
Prostate Problems	□ Yes □ No	Breastfeeding Patient	□ Yes □ No
Cancer	□ Yes □ No	***(if receiving IV contrast, refrain from feeding for 24hr)***	

PREVIOUS MEDICAL HISTORY:

Have you had any prior Surgeries? □ Yes □ No

If yes, please list date and type of Surgery_____

_____

Are you allergic to any type of food, medications or imaging contrast (dye) □ Yes □ No

If Yes, what Type? _____

I understand the information presented to me and have answered all the questions to the best of my knowledge.

_____ _____ _____

Signature of person providing information ***Relationship to patient*** ***Date***

(For Imaging Personnel Only)

Technologist Comments: _____

_____

Technologist Signature: _____ **Date:** _____

Contrast Admin: _____ **Amt:** _____ (cc) ___**GFR:** _____**Creatine:**_____