

PLEASE FILL OUT THE FORM BELOW. THIS WILL ENABLE US TO DO A SAFE AND ACCURATE EXAMINATION.

DESCRIBE THE MEDICAL PROBLEM(S) AND SYMPTOMS WHICH BROUGHT YOU HERE TODAY:

HAVE YOU HAD ANY PREVIOUS SURGERIES? YES _____ NO _____

IF SO, PLEASE LIST:

ARE YOU ALLERGIC TO IODINE? YES _____ NO _____ (V15.08)

ARE YOU A DIABETIC? YES _____ NO _____ (250.0)

IF SO, ARE YOU TAKING GLUCOPHAGE OR GLUCOVANCE FOR YOUR DIABETES? YES _____ NO _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

ASTHMA (493.9) YES _____ NO _____

EMPHYSEMA? (492.8) YES _____ NO _____

HEART DISEASE? 429.9 YES _____ NO _____

DO YOU HAVE ANY KIDNEY PROBLEMS? YES _____ NO _____ (593.9)

IF SO, PLEASE EXPLAIN:

PLEASE LIST ANY PREVIOUS CT STUDIES OR OTHER IMAGING STUDIES SUCH AS MRI, XRAY, OR ULTRASOUND, ALONG WITH THE APPROXIMATE DATES AND WHERE THEY WERE PERFORMED.

- 1. _____
- 2. _____
- 3. _____

BY SIGNING BELOW, YOU INDICATE THAT YOU HAVE READ THE ABOVE INFORMATION AND ANSWERED ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. FURTHER YOU AGREE TO BE IMAGED USING COMPUTED TOMOGRAPHY.

SIGNATURE

DATE

WITNESS

MEDICAL OFFICE USE ONLY

ORAL CONTRAST: _____ IV CONTRAST: ISOVUE 300/100 ml _____
 ISOVUE 370/100 ml _____
 ISOVUE 370/150 ml _____

EXAM NOTES: _____
