

**SOUTH DENVER IMAGING**  
**CT AND IV CONTRAST HISTORY AND SCREENING FORM**

Today's Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Patient Name \_\_\_\_\_ Sex: M F  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Explain your medical problem in detail that is the reason for you having this CAT Scan test today.  
 (Where is the problem? How long have you had this problem?)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had a previous exam related to this problem? Yes No If yes, where was the exam performed? \_\_\_\_\_

List other medical problems: \_\_\_\_\_

List previous surgeries: \_\_\_\_\_

List all allergies: \_\_\_\_\_

Any chance you could be pregnant? \_\_\_\_\_

**CONTRAST HISTORY**

Are you taking Glucophage (a diabetic medication)? Yes No

BUN \_\_\_\_\_ CREATININE \_\_\_\_\_

Have you ever had an allergic reaction to x-ray contrast? Yes No

If yes, explain: \_\_\_\_\_

Any personal history of:

Asthma	Yes	No
Diabetes	Yes	No
Kidney Disease	Yes	No
Cancer	Yes	No
Multiple Myeloma	Yes	No
Are you breast-feeding?	Yes	No

Comments: \_\_\_\_\_  
 \_\_\_\_\_

I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time.

\_\_\_\_\_  
 PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE      TECHNOLOGIST/WITNESS SIGNATURE      DATE

<b>Not applicable to this exam <input type="checkbox"/></b>			
_____	CC With a _____	@ _____	X _____
<b>Amount</b>	<b>GA &amp; Needle Type</b>	<b>Time</b>	<b># of punctures</b>
<b>In</b> _____	<b>Lot</b> _____	<b>Expiration Date:</b> _____	
<b>Site Location</b>	<b>By:</b> _____		
<b>Contrast Reaction <input type="checkbox"/> Yes <input type="checkbox"/> No</b>	<b>Physician Covering Contrast</b>		
<b>Explain</b>	_____		