SUMMIT MEDICAL GROUP

CT Questionnaire/History Sheet

MRN# DOB:

Patient Name: Date:

Provider:

Patient Name: _____ Ordering Provider**:** _____

Reason for today's exam: _____

Patient History- *Please check off boxes, and provide explanation to all YES answers:*

Allergies: ☐ YES ☐ NO If yes, please explain: _____

Diabetes: ☐ YES ☐ NO If yes, list medication(s): _____

Heart Disease: ☐ YES ☐ NO If yes, please explain: _____

Kidney Disease: ☐ YES ☐ NO If yes, please explain: _____

Multiple Myeloma: ☐ YES ☐ NO If yes, please explain: _____

Female Patients Only:

Are you pregnant or nursing? ☐ YES ☐ NO

Signature

I have answered all the above questions to the best of my ability.

_____ _____

Patient Signature (or person authorized to sign for Patient) Date

_____

Relationship to Patient if signing for Patient

_____ _____

Interpreter Signature (or ID# if using service), as applicable Date

To be completed by Technologist only:

If patient is diabetic, and documented use of Glucophage Therapy: Glucophage / Metformin / Metaglip / Avandamet / Glucovanc – review dept protocol

If patient had a previous reaction to iodinated x-ray dye/contrast, please verify if patient was treated for exam

Date Lab Collected: _____BUN _____ Creatinine _____ Labs Unavailable: _____
Normal Range: BUN (7-30) Creatinine (.6-1.5) Radiologist/Referring Physician Signature: _____

IV contrast used: Omnipaque 300 / Omnipaque 350 Time of Injection: _____ Site of Injection: _____

Angiocatheter used: ☐ 18 gauge ☐ 20 gauge ☐ 22 gauge ☐ 24 gauge

Technologist Signature: _____ Date: _____