Summit Health CityMD

Imaging's CT Department Patient History Sheet

Patient Name: _____ MRN#: _____

D.O.B. _____ Ordering/Referring Physician: _____

Reason for today's exam: _____

_____

_____

Surgical History: _____

Do you have a history of: (Please check)

Allergies: ☐ YES ☐ NO

If YES, please explain: _____

Diabetes: (If YES, please list medicines) ☐ YES ☐ NO

_____

(If currently on Glucophage Therapy: Glucophage/Metformin/Metaglip/Avandamet/Glucovanc,review dept. protocol)

Heart/Kidney Disease: ☐ YES ☐ NO

Multiple Myeloma: ☐ YES ☐ NO

Are you pregnant/nursing? ☐ YES ☐ NO

Patient Signature: _____ Date: _____

CT TECHNOLOGIST/ RN ONLY

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

Date Lab Collected: _____ eGFR_____ Lab Unavailable: _____

eGFR <30 Radiologist/ Physician Signature: _____

Name of IV contrast used: Omnipaque _____Time of Injection: _____Site of Injection: _____

Angio Cather used: ☐ 18 gauge ☐ 20 gauge ☐ 22 gauge ☐ 24 gauge

_____ _____

Date Technologist / RN Signature

Additional Notes/Comments: (use additional sheets if required) _____