Diagnostic Imaging Center of Terrebonne
a TGMC affiliate

CT Patient History and Screening Form

Name:_____ D.O.B.:_____ Acct #:_____
Referring Physician:_____ Follow-up Appt with MD _____
Please describe the reason for this exam: _____
_____
How long have had these symptoms:_____
Are you taking medications for these symptoms: YES NO If yes, what:_____
Do you have a history of cancer? YES NO If yes, what type and when were you diagnosed:_____
_____
Previous Surgeries (please circle)

Y N	Gallbladder	Y N	Appendix	Y N	Stomach
Y N	Colon	Y N	Small Bowel	Y N	Hysterectomy
Y N	C-Section	Y N	Kidneys	Y N	Liver
Y N	Ovaries	Y N	Hernia	Y N	Prostate
Y N	Brain	Y N	Head/Neck	Y N	Esophagus
Y N	Heart	Y N	Breast	Y N	Lung

Other Surgeries, please list: _____
Do you or have you ever smoked: Y N Have you ever had a head injury: Y N
Do you have a history of kidney stones: Y N Do you have a history of seizures: Y N
Do you have blood in your urine: Y N Do you have any vision changes: Y N
Do you have abdominal pain: Y N
Have you had a previous X-Ray, CT Scan or MRI: Y N If yes, please list the date and most recent studies:
Type of Exam:_____ Date:_____ Location:_____
Type of Exam:_____ Date:_____ Location:_____
Do you have any of the following medical conditions: (please circle)

Y N	Diabetes	Y N	High blood pressure & age over 65
Y N	Multiple myeloma	Y N	Renal (kidney) insufficiency/failure
Y N	Sickle Cell Anemia	Y N	Polycythemia
Y N	Pheochromocytoma	Y N	Collagen Vascular Disease
Y N	Allergies/Asthma	Y N	Heart Disease

Have you been given an X-Ray dye/contrast injection before: Y N
If yes, which study: (please circle) CT Scan IVP Cardiac Cath Other:_____
Have you been given an X-Ray dye/contrast injection within the past 24 hours: Y N
Have you had an allergic reaction to X-Ray Dye/Contrast: Y N
If yes, please describe the contrast and reaction if possible: _____
_____
Do you have a latex allergy: Y N Have you eaten in the last four hours: Y N
Is there any chance you could be pregnant: Y N
Do you have Heart Disease: Y N If yes, please specify: (please circle)
Angina at rest or upon exertion Recent Heart Attack (within 2 weeks) Arrhythmia (uncontrolled by meds)
Heart Failure (shortness of breath at rest or upon mild exertion) Other:_____
Are you currently taking any of the following medications: (please circle)
Y N Glucophage Y N Metformin Y N Glucovance Y N Insulin
Y N Anti-inflammatory drugs:_____ Y N Antibiotics:_____
Y N Any other oral diabetes medication:_____

Technologist Signature: _____ Date:_____

Patient Signature: _____ Date:_____