ImageCare

Patient History

Name: _____ Date of Birth:_____ Date: _____Ht.___Wt____

Please describe your current symptoms in detail (include duration):

_____

_____

Have you ever had a CT? NO YES

Have you ever had IV Contrast? NO YES

Have you ever had a reaction to IV contrast? NO YES

If YES, please explain: _____

Please list any known allergies: _____

Please list all current medications: _____

_____

Please list all previous surgeries: _____

Do you have a history of: (Please circle YES or NO)

High Blood Pressure	Y	N	Tuberculosis	Y	N
Heart Problems	Y	N	Hepatitis	Y	N
Asthma	Y	N	Pheochromocytoma	Y	N
Lung Problems	Y	N	Sickle Cell Disease	Y	N
Do you use an inhaler	Y	N	Diabetes	Y	N
Kidney Problems	Y	N	Glucophage/Metformin	Y	N
Personal history of cancer	Y	N	Smoker	Y	N
Radiation Therapy	Y	N	Chemotherapy	Y	N
Are you Right handed_____ Left Handed_____			Ex-Smoker	Y	N

Are you pregnant? Y N Are you breastfeeding? Y N

Other previous or related testing: _____

_____

Is this an injury related illness: Y N Date of Accident: _____

Patient: _____ Technologist: _____

Signature Signature

Tech notes_____

_____

Contrast Dose: _____ (Name, Dosage and Vial Size) Pacs list___Nuance___MDM___