Wake Forest Baptist Outpatient Imaging
CT History Form

Name: _____ Date: _____

DOB: _____ Referring Physician: _____

General Questions

1 Please explain your current problem in detail: _____

_____

2 How long has this problem been occurring? _____

3 Have you had any current bloodwork within the past 30 days? _____

If yes, where? _____

4 Have you had any trauma or injury? _____

5 Females: Last Menstrual Cycle? _____ Any chance of pregnancy? _____

Please answer Yes or No to the following questions. If yes, please explain on line.

	Yes	No	
1	☐	☐	Have you ever been injected with Intravenous Contrast Material (X-ray Dye)?
2	☐	☐	Have you ever had a reaction to X-ray Dye? If yes, what kind? _____
3	☐	☐	Have you had any other studies performed on this body part? If yes, where and when? _____
4	☐	☐	Do you currently take any medications? If yes, what?_____ _____
5	☐	☐	Are you allergic to any medications? If yes, please list_____ _____
6	☐	☐	Are you allergic to any foods or to latex gloves? _____
7	☐	☐	Have you had any surgery to the area being scanned today? If yes, what kind? _____
8	☐	☐	Do you have a history of high blood pressure or hypertension?
9	☐	☐	Do you have a history of asthma?
10	☐	☐	Do have a history of cancer? If yes, what type? _____ Have you had any treatments? If yes what kind and when? _____
11	☐	☐	Are you diabetic? If yes, what medication do you take? _____
12	☐	☐	Do you have impaired renal function? Kidney Disease?
13	☐	☐	Do you have Multiple Myeloma?
14	☐	☐	Do you have a Pacemaker or Defibrillator?
15	☐	☐	Do you have a Neurostimulator?
16	☐	☐	Do you have any other electronic implanted devices? If yes, what? _____

I attest that the answers that I have provided to questions on this form are correct to the best of my knowledge.
I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature: (Parent or Guardian)_____Date: _____

Technologist notes: Tech Signature_____

Oral Contrast: _____ IV Contrast: _____ Amount Given: _____cc

BUN: _____ Creatinine: _____ GFR: _____ Date Drawn: _____