Wake Forest Baptist Outpatient Imaging
CT History Form

Name: ______________________ Date: ______________________

DOB: ______________________ Referring Physician: ______________________

General Questions

1 Please explain your current problem in detail: ______________________

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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:

Oral Contrast: __________ IV Contrast: __________ Amount Given: __________ cc

BUN: __________ Creatinine: __________ GFR: __________ Date Drawn: __________