BEXAR IMAGING
A WellMed Company

Technologist's Initials

CT HISTORY AND SCREENING

Name_____ Age_____

Date of Birth____/____/____ Sex: M / F Height_____ *Weight_____ (<400lbs)

Please list drug allergies_____

Have you had this same exam elsewhere? If so, where?_____

Yes No Have you ever been injected with an x-ray dye?
Yes No Did you have an adverse or allergic reaction? **If YES**, please describe_____

DO YOU HAVE A HISTORY OF:

Yes No Allergy to iodine, shellfish or seafood?
Yes No Arrhythmia? (irregular heartbeat)
Yes No Pulmonary Hypertension?
Yes No Heart Disease?
Yes No Pheochromocytoma (Tumor above the kidneys)?
Yes No Any severe debilitating disease?
Yes No Sickle cell disease?
Yes No Kidney problems/failure?
Yes No Cancer? If so, what type? _____

ARE YOU:

Yes No A dialysis patient?
Yes No Diabetic?
Yes No Taking Glucophage or Metformin?
Yes No Breastfeeding or pregnant?
Yes No Taking any blood thinners (such as Aspirin or Coumadin)?
Yes No Taking any diuretics (water pills)?
Yes No Have the following been removed? (circle) gallbladder, kidney, uterus, appendix, Breast (R / L)
Yes No Do you have an ostomy bag or a feeding tube? If so, DO NOT Drink Oral contrast
Yes No Are you allergic to tape or latex?

TECH NOTES

Please describe surgeries you have had and the approximate date of each surgery:

_____ Date____/____/____

_____ Date____/____/____

_____ Date____/____/____

I have answered the above questions to the best of my knowledge.

Patient / Guardian Signature_____ Date____/____/____

If Guardian, Printed Name _____

UPDATED

Patient / Guardian Signature _____ Date____/____/____

If Guardian, Printed Name_____