RADDICO
RADIOLOGY DIAGNOSTIC IMAGING CORPORATION

Patient Medical History Questionaire for CT Scans

Name _____ DOB _____

Referring Physician(s) _____ Date _____

Present Complaint/Pain _____

Patient History

Have you had a prior CT scan? **Y N**
If Yes, where? _____
Date_____

Could you be pregnant? **Y N**

Date of last period _____

History of hypertension? **Y N**

Asthma? **Y N**

Heart Disease? **Y N**

Diabetes? **Y N**

If yes are you talking Glucophage (Metformin) Glucovance, or Avandament?
_____

Are you claustrophobic? **Y N**

INITIAL_____

Have you ever had surgery? **Y N**
If yes, what type? _____
_____

Have you had Radiation Therapy? **Y N**

If yes, how many treatments? _____

Have you ever had Chemotherapy? **Y N**

Sickle Cell Disease? **Y N**

Multiple Myeloma? **Y N**

Cancer? **Y N**

If yes what type _____

Renal (Kidney) Disease? **Y N**

Do you have any medical devices or metals in your body?? **Y N**
If yes Where? _____
What type? __ _____

History of Allergies

Foods? Yes_____ No_____ If yes what? _____
Environmental? Yes_____ No_____ If yes what? _____
Medicines? Yes_____ No_____ If yes what? _____

Contrast Reaction / Allergy

Have you ever had allergic reaction to Iodine (X-Ray Contrast)? Yes_____ No_____

What type of reaction? Nausea_____ Vomiting_____ Hives_____ Difficulty Breathing_____Sneezing_____ Other_____

What treatment for the reaction did you receive? _____

Have you had contrast since the reaction? Yes_____ No_____

Were there any problems? Yes_____ No_____ What type of problems?_____

Were you pre-medicated? Yes_____ No_____ Name of the Medication_____

Patient/Guardian Signature_____ Date_____