

Patient Name: _____

Date: _____

Time: _____

CT SCAN Patient Information Sheet

1. What symptoms are you having that led your doctor to order this CT Scan?

2. Are you currently taking medications for this or other problems? Yes No
If yes, please list: _____

3. Are you diabetic? Yes No
If yes, what medication are you on? _____
4. Do you have any allergies to foods or medicines? Yes No
If yes, please list: _____
5. Have you ever had an exam during which you received an injection of contrast material or dye? Yes No If yes, what exam? () CT () MR () Other
6. Did you have any type of reaction to the contrast or dye? Yes No
If yes, describe: _____
7. Please check off any medical problems you may have:
() History of Asthma () Sickle Cell Anemia () Chronic Renal Failure
() Multiple Myeloma () Heart Disease () Other _____
() Respiratory Failure () Unstable Angina () Other _____
8. Have you ever been x-rayed here before? Yes No
If yes, when? _____
9. Is there any chance that you may be pregnant? Yes No Not Sure
10. Are you breast feeding? Yes No
11. What is your weight and height? _____
12. Can you comfortably walk, sit and stand on your own (fall risk assessment)? Yes No

Form completed by:

Patient (or guardian): _____	Relative (name & relationship): _____
Physician: _____	
Signature: _____	Reviewed/Approved by: _____
Date: _____	Date: _____