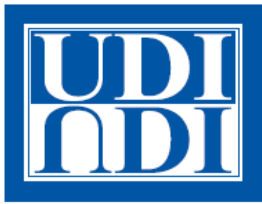

University Diagnostic Institute

Winter Park • Longwood • Orlando

TECHNOLOGIST USE ONLY

Date / /
Tech Signature

CT SCREENING FORM

Last Name	First Name	Phone ( )

☐ Female ☐ Male	D.O.B / /	Age	Height	Weight

Emergency Contact	Phone ( )

Reason for CT Scan today?____

Symptoms related to Injury? ☐ YES ☐ NO ☐ Auto Accident? ☐ Work Related? ☐ Other? DOA / DOI:____________

Please list/describe symptoms you are experiencing:____

Female patients only: Are you or do you suspect that you are pregnant? ☐ YES ☐ NO

Are you breast feeding? ☐ YES ☐ NO

When was your last menstrual period? Date:________________

SURGERY HISTORY

Have you had surgery to the body part being scanned today? ☐ YES ☐ NO

If YES, please describe: ______________________________

Do you have a Cardiac Pacemaker ☐ YES ☐ NO

Implanted Orthopedics ☐ YES ☐ NO
(pins, rods, screws, clips, wires, limbs/joints)

Please list all other surgeries:______________________________

MEDICAL HISTORY

Please indicate if you have the following:

Multiple Myeloma ☐ YES ☐ NO

Liver Disease ☐ YES ☐ NO

Blood Disease ☐ YES ☐ NO

Sickle Cell Disease ☐ YES ☐ NO

Anemia ☐ YES ☐ NO

High Blood Pressure ☐ YES ☐ NO

Cancer ☐ YES ☐ NO

If YES, type and date diagnosed: ________________________

Pheochromocytoma (Adrenal Gland Disease) ☐ YES ☐ NO

Do you smoke ☐ YES ☐ NO

If YES, How Much:_______________

How Long:__________________

Ex-Smoker ☐ YES ☐ NO

Non-Smoker ☐ YES ☐ NO

PREVIOUS IMAGING STUDIES

Have you had previous imaging studies to the area being scanned today? ☐ YES ☐ NO

If YES, please list and provide dates:

____

____

____

HISTORY OF CONTRAST

Are you allergic to Iodine or Contrast Dye? ☐ YES ☐ NO

Have you ever had an allergic reaction to Iodine or Contrast Dye? ☐ YES ☐ NO

If YES, please describe the type of reaction: ________________

____

Do you have any allergies? ☐ YES ☐ NO

If YES, please describe: ______________________________

Do you take Blood Thinners? ☐ YES ☐ NO

Do you take daily Aspirin? ☐ YES ☐ NO

Do you have Kidney Disease ☐ YES ☐ NO

Do you have Diabetes? ☐ YES ☐ NO

If YES, are you taking any of the following?

☐ Glucovance	☐ Janumet	☐ Fortamet
☐ Actoplus Met	☐ Riomet	☐ Metaglip
☐ Avandamet	☐ Prandimet	☐ Other
☐ Metformin	☐ Glucophage	

*****If YES, to Kidney Disease or Diabetes*****
BUN/CREATINE Labs are required with 60 days

Date of last blood work:______________________________

Facility labs were done:______________________________

PATIENT SIGNATURE

I attest that the above information is correct to the best of my knowledge. <u>I give consent to have a contrast agent administered to me</u> if needed for proper diagnosis of my procedure. I have read and understand the contents of this form and I have had the opportunity to ask questions regarding the information on this form.

______________________________ ______________________________

PATIENT/PARENT/LEGAL REPRESENTATIVES SIGNATURE **DATE**