TOWER RADIOLOGY

CT SAFETY QUESTIONNAIRE

Name: _____ DOB: _____ Height: ____ Weight: ____

Date: _____ Referring Doctor? _____

1. What complaints/symptoms led you to see the doctor? _____
   Duration of symptoms _____

2. Diabetes	Yes	No	Diabetic medication_____ How long__
Do you take metformin?	Yes	No	Date last taken: _____
3. Kidney Disease	Yes	No	
Dialysis	Yes	No	Next Dialysis _____
Pheochromocytoma	Yes	No	
4. Cardiac Problems	Yes	No	Medications: _____
Stroke	Yes	No	
5. Personal Cancer History	Yes	No	Type and date diagnosed _____
Chemo	Yes	No	Date of last treatment _____
Radiation	Yes	No	Date of last treatment _____
6. Multiple Myeloma	Yes	No	
7. Weight loss	Yes	No	Amount ___lbs. Time frame _____
8. Respiratory Problems	Yes	No	Please circle: Asthma Emphysema Bronchitis
History of smoking	Yes	No	
9. Alcohol Consumption	Yes	No	
10. High Blood Pressure	Yes	No	

11. Please list ALL prior surgeries and dates:

_____

_____

12. Please list all other medications:

_____

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ALLERGY HISTORY

1. Personal Allergy History: Please indicate type of reaction (severity) and treatment if any.

Medications_____

Food_____

Environmental Agents_____

2. Previous injection of x-ray dye for exams such as Angiogram, IVP or CT?

YES NO

Any reaction or problems after receiving dye?_____

3. Any history of kidney disease or dialysis? If yes, explain:_____
_____

***Please indicate if you have or take an inhaler for any medical reason.**

YES NO Do you have the inhaler here with you today?_____

CONSENT FOR CT/MRI CONTRAST AND PROCEDURE

Patient Name_____

I understand the CT/MRI Scan may require an injection of contrast material. The risks of having a contrast reaction were discussed and noted to include, but are not limited to, various types of allergic reactions. Most of these reactions are minor, although they can be severe at times. On rare occasions, inflammation or infection at the site of injection can occur. Very rarely complications can be so severe death can occur.

I acknowledge that all risks of the CT scan and the injection required for my study have been explained to me. I authorize Tower Radiology, LLC to perform the indicated CT study and to inject the contrast medium needed for my exam.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Signature of Technologist Date

_____ _____
Signature of Radiologist Date

Contrast Information

Lot # _____ Expiration_____ Amount_____
Tech_____Complications_____

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