
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:



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? _____

***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 _____