Imaging
AUGUSTA UNIVERSITY HEALTH

CT History Form

PATIENT INFORMATION **Fall Precaution** ☐ YES ☐ NO

Last Name	First Name/Middle Initial	Gender	Race
Date of Birth (MM/DD/YYYY) / /	Age	Height	Weight

PERSONAL HISTORY

Have you had a previous imaging study related to this problem? ☐YES ☐NO
If yes, What exam? ☐CT ☐MRI ☐Ultrasound ☐X-ray ☐Other
What Facility?
_____

Heart Disease	☐YES ☐NO	High Blood Pressure	☐YES ☐NO	Kidney Disease	☐YES ☐NO
Asthma	☐YES ☐NO	Smoking	☐YES ☐NO	Kidney Failure	☐YES ☐NO
Lung Disease	☐YES ☐NO	Diabetes	☐YES ☐NO	Dialysis	☐YES ☐NO

Allergies ☐YES ☐NO If yes, please explain: _____
Surgeries ☐YES ☐NO If yes, please explain: _____
Cancer ☐YES ☐NO If yes, please explain: _____
Do you take Metformin hydrochloride (Glucophage, Glucovance, Advandement, Metaglip, or Fortamet)? ☐YES ☐NO
Have you ever had an allergic reaction to injected contrast (x-ray dye) ☐YES ☐NO
If yes, please explain: _____

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding ☐ YES ☐ NO Date of last period: _____

FOR TECH USE ONLY

Contrast: _____ Dose: _____ mL Inj. Rat: _____ cc/sec iStat Creatinine: _____
IV Site: R L _____ IV Size: _____ g # Attempts: _____ Initials: _____

ACKNOWLEDGMENT

I have answered these questions to the best of my knowledge and understand the information presented to me.
If I am to have intravenous contrast with my procedure, I have been informed of the risks.

PATIENT/GUARDIAN SIGNATURE DATE

TECHNOLOGIST SIGNATURE DATE