

**PREMIER MEDICAL IMAGING
CT Scan Consent & Screening Form**

Date: _____ Name: _____

Weight: _____

INSTRUCTIONS TO PATIENT: Please complete the following questions to the best of your knowledge. The technologist and physician performing the examination will use this information.

1. Have you had any recent diagnostic exams that are related to your visit today?
(please check all that apply) CT MRI X-Ray PET Nuclear Medicine Ultrasound Mammogram DEXA

Where & when were the procedures performed? _____

- | | | | | |
|-----|---|-----|----|-----------------|
| 2. | Have you ever had a Cat Scan or IVP before? | Yes | No | (please circle) |
| 3. | Do you have a history of adverse reaction to IV contrast material
(excluding heat, flushing, or nausea/vomiting) | Yes | No | (please circle) |
| 4. | Did you eat or drink anything in the last 3 hours? | Yes | No | (please circle) |
| 5. | Do you, or have you ever used, tobacco products?
If yes, what type and how long? _____ | Yes | No | (please circle) |
| | Have you been diagnosed with sickle cell anemia | Yes | No | (please circle) |
| 6. | Have you been diagnosed with kidney failure? | Yes | No | (please circle) |
| 7. | Do you have a history of asthma? | Yes | No | (please circle) |
| 8. | Do you have an active heart condition? | Yes | No | (please circle) |
| 9. | Do you have a history of diabetes? | Yes | No | (please circle) |
| 10. | Is the patient on glucophage, metformin, metaglip, advandia, or glucovance | Yes | No | (please circle) |
| 11. | Do you have any drug allergies?
List them: _____ | Yes | No | (please circle) |

- | | | | | |
|-----|--|-----|----|-----------------|
| 12. | <div style="border: 1px solid black; padding: 2px; display: inline-block;">FEMALE PATIENTS</div> Is there a possibility of pregnancy at this time? | Yes | No | (please circle) |
| | Are you currently breast-feeding? | Yes | No | (please circle) |

13. Have you had surgery in your lifetime? Yes No (please circle)

What Kind?	When?	Reason?

14. Have you ever had cancer in your lifetime? Yes No (please circle)

What Kind?	When?	Treatment?

15. Are you currently taking any medications? Yes No (please circle)
If **yes**, please list them: _____

16. Do you have any other major medical problems (for example: anemia, organ transplants, sickle cell anemia)? _____

Please list all the symptoms that you are experiencing, or have experienced with your complaint and shade in those areas on diagram 1 below.

How long have you been experiencing this/these symptoms? _____

Do you or your doctor feel a mass? Yes No (please circle)
If **yes**, please note the mass on the diagram 1 below.

For office use only

Hx: _____

For patient use: Diagram 1

I understand that the exam to be performed involves the use of IV contrast media and that there are possible, but infrequent complications. The complications can range from a mild skin rash to a life threatening allergic reaction that is extremely rare (1 in 30,000). I hereby consent to the administration of IV contrast media. I also give consent to any measure necessary to correct complications that may occur.

Signature (patient or guardian)

Date

Witness (technologist)

FOR TECHNOLOGIST USE ONLY

Has the patient been informed to discontinue the use of glucophage, metformin, glucavance, avandia, or metaglip for 48 hours after the exam and to consult physician prior to resuming medications?

COMMENTS: _____
CONTRAST: _____ AMOUNT: _____ CC'S