Computed Tomography (CT) History Form

Why are you having this CT exam? _____
If this CT exam is related to an injury, how did it occur? _____
If this CT exam is related to pain, where is the pain located? _____
List any surgeries related to your area of CT exam_____

YES	NO	Answer Questions Below	Fill in, as applicable
		Do you have a history of cancer?	Type of Cancer:
		If yes, Did you have □ Chemotherapy or □ Radiation?	Date of last treatment:
Female Patients (ages 12 – 50)			
		Are you pregnant or is there any possibility that you could be?	Specify weeks pregnant:
		Was your last menstrual period (LMP) greater than 4 weeks ago?	Date of LMP:
For Patients receiving IV Contrast			
		1. Do you have multiple myeloma, adrenal tumor (pheochromocytoma), myasthenia gravis (gMG), or auto immune disease?	Specify:
		2. Do you have a history of hypertension requiring medical therapy?	
		3. Do you have Renal cancer or had Renal surgery?	Specify Date of Surgery:
		4. Do you have renal impairment?	
		5. Do you have only one functioning kidney or had a kidney transplant?	Specify Date of Surgery:
		6. Are you diabetic?	
		7. Do you take Metformin, Glumetza, Fortamet, Riomet, Glucophage, Glucophage XR, or Metformin-containing medications?	Specify medication:
		8. Are you on dialysis?	
		8a. If yes to #8, Do you make at least 1 to 2 cups of urine daily?	
		9. Are you allergic to Iodine, or Imaging contrast?	Specify reaction & date:
		9a. Were you pre-medicated prior to this CT exam?	Medication Name: Dosage: Time:

_____ _____
Name of person who provided information Relationship to patient

_____ _____ _____ _____
Interviewer/ Person completing form Authentication Print Name Date Time
☐Phone
_____OR ☐Video
Qualified Staff / Interpreter Signature (Check) _____ _____ _____
Print Qualified Staff / Interpreter Name ID Number Language Interpreted

For staff use only

eGFR: _____ **Creatinine:** _____ **Date:**_____ **Time:** _____

Current Weight in kg _____
Height in cm_____

- **eGFR Required - If patient is age 60 or older or "Yes" to question(s) #1-7.**
  - If GFR **30 or greater**, give contrast per protocol.
    If GFR **29 or less**, contact Radiologist
- Question 8a - *Do you make at least 1 to 2 cups (8 to 16 ounces; 236 to 473 milliliters) urine daily?*
  - *If yes, call Radiologist to determine if contrast is needed.*
  - *If no urine, scan with contrast, no discussion with Radiologist needed.*
- If answer "Yes" to question #9/9a - refer to CT Pre-Procedure IV Contrast Power Plan / Radiology Contrast Allergy Prophylaxis SubPhase

***In the event of an additional exam within a 24-hour period, do not call Radiologist for re-injection clearance when eGFR is greater than 30 & total iodinated contrast will not exceed 250mL*.**

_____ _____ _____ _____
Technologist Authentication Print Name Date Time

Patient Label or

Patient Name_____ ☐Female ☐Male

DOB_____ MRN_____