**NAME**_____ **Wt**_____**DOB**_____ **DATE**_____**TIME**_____

| | | |
|---|---|---|
| Please list any medications you are allergic to including Iodine or contrast dye. | ☐ NKDA | |
| Do you have any asthma, hay fever, or pulmonary disease? (COPD, Emphysema) | ☐ Yes | ☐ No |
| Do you take medication for high blood pressure? | ☐ Yes | ☐ No |
| Do you have diabetes? | ☐ Yes | ☐ No |
| Do you take Hydroxyurea, Metformin/Glucophage, Janumet, Glumetza, Kombiglyza, Jentadueto, Actosplusmet, Glucovance, Metaglip for any conditions? | ☐ Yes | ☐ No |
| Do you have any kidney disease?<br>If yes, (only have one kidney, renal transplant, kidney stone, dialysis next appt _____) | ☐ Yes | ☐ No |
| Do you have any blood disorders? (hepatitis, HIV, AIDS) | ☐ Yes | ☐ No |
| Do you have any Neurological disorders? (seizures, brain tumor, stroke, TIA) | ☐ Yes | ☐ No |
| Do you have any history of cancer? If so, please list type: _____<br>Is this scan for: ☐ Initial staging ☐ Restaging Date of diagnosis: _____<br>Chemotherapy: last treatment date: _____<br>Radiation therapy: last treatment date: _____ | ☐ Yes | ☐ No |
| Have you had the following surgeries?<br>Appendectomy<br>Gallbladder<br>Hysterectomy | ☐ Yes<br>☐ Yes<br>☐ Yes | ☐ No<br>☐ No<br>☐ No |
| Please list any other surgeries. If less than 30 days, please provide date<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ | | |
| Female patients 50 and younger, is it possible that you could be pregnant?<br>Date of last menstrual period_____ | ☐ Yes | ☐ No |

Patient Signature_____ Date_____

**Hospital Use Only:**

Injection site: _____ # of attempts: _____ Needle Gauge: _____ Injected by: _____ IV Dc'd by: _____ Time: _____

Creatinine:_____ GFR: _____ Date:_____

RUN#:_____

**Is pt on Oxygen?** ☐ Yes _____ liters ☐ No

☐ ISOVUE 300 _____cc ☐ ISOVUE Oral ☐ Neulumex _____ ml

☐ ISOVUE 370 _____cc ☐ Barium

☐ Other _____ ☐ Rectal

Procedure information according to Radiology teaching guidelines reviewed/questions answered: ☐ Yes ☐ No

Patient verbalizes understanding of the information given: ☐ Yes ☐ No

Was a Glucophage/Metformin aftercare instruction form given to patient? ☐ Yes ☐ No

Comments_____

_____ _____

Scanning Technologist Paperwork Technologist

Date_____ Time _____

**CAT SCAN PRE-EXAM INTERVIEW**

AdventHealth Imaging Center
Roeland Park, KS 66205



RADHXSC