CT Screening

Patient Name: _____ MRN: _____

Weight:_____ Height: _____

□ Y □ N **Are you taking any medications for blood pressure?** *If yes, what*: _____

□ Y □ N **Do you have a history of cancer?** *If yes, Type:* _____
When was your last chemo/radiation treatment? _____

□ Y □ N **Have you ever had an organ transplant?** *(Heart, Lungs, Liver, Kidney)* _____

□ Y □ N **Have you ever had any other surgical procedures of any kind?** *If yes, please list:*
_____

□ Y □ N **Have you had any recent infections?** *If yes, where?* _____

□ Y □ N **Are you diabetic?** *If yes, list medications:* _____

□ Y □ N **Any possibility that you are pregnant or are you actively trying to get pregnant?**
□ Y □ N **Are you currently nursing?**
□ Y □ N **Have you had an Iodine Contrast injection recently? If yes, when?_____**
□ Y □ N **Are you allergic to Iodine Contrast?** *If yes describe* : _____
□ Y □ N **Do you have any allergies*? (food, medications, etc)****If yes, please list*: _____

□ Y □ N **Have you had lab work drawn within the last 30 days?** *Where*? _____

□ Y □ N **Have you ever been diagnosed with kidney disease?** □ **Y** □ **N**
Have you ever been seen by a kidney specialist? □ *Y* □ *N*
Have you ever had kidney surgery? □ *Y* □ *N*
Have you ever had decreased kidney function? □ *Y* □ *N*
Ever had dialysis? □ *Y* □ *N* *Was it hemodialysis or peritoneal dialysis:* _____

Do you have any of the following medical conditions?

□ Y □ N Asthma?
□ Y □ N Liver disease/Hepatitis?
□ Y □ N Diagnosed arthritis?
□ Y □ N Are you on any fluid restrictions?
□ Y □ N Heart disease?
□ Y □ N CHF (**C**ongestive **H**eart **F**ailure)?
□ Y □ N Intestinal or bowel disease?
□ Y □ N Have you had any other medical imaging exams related to today's study?
When? _____ *Where?* _____

Patient signature: _____ Date: _____

FOR OFFICE USE ONLY: Please do not write below

NPO since: _____

Patient's primary complaint: _____

_____

_____ Screeners signature:_____ Date:_____

F/U appt. _____Interviewer signature: _____ Date: _____

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