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 Heart disease?

□ Y □ N Liver disease/Hepatitis? □ Y □ N CHF (**C**ongestive **H**eart **F**ailure)?

□ Y □ N Diagnosed arthritis? □ Y □ N Intestinal or bowel disease?

□ Y □ N Are you on any fluid restrictions?

□ 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:**

Rev 6/14/2016

**Date:**