ChristianaCare™

ENCBASFRM

DOB: /
Admit Date: MRN:
ECD:

COMPUTERIZED TOMOGRAPHY (CT) SCAN HISTORY

SECTION I: TO BE COMPLETED BY PATIENT/REPRESENTATIVE PRIOR TO CT SCAN

Referring/ordering physician (Name): _____
Contact information (Address/Phone #): _____
Other physician(s) needing reports: _____
Contact information (Address/Phone #): _____
Height: _____ Weight: _____ ☐ Male ☐ Female Age: _____
Are you pregnant or possibly pregnant? ☐ No ☐ Yes ☐ Not applicable Last menstrual period: _____ /_____ /_____
Please explain, in detail, the reason for your examination today (include specific medical problems, location and how long you've had the problem): _____
_____
List other medical problem(s): _____
List previous surgeries: _____
Medical test: If you have had a CT Scan, when was it performed and where?

When	Where	When	Where

CONTRAST HISTORY

Are you taking any diabetic medication? ☐ No ☐ Yes, what is it: _____
When did you last take it? _____
Have you ever had a previous allergic reaction to X-ray contrast (dye)? ☐ No ☐ Yes, explain: _____
_____
Have you been pre-medicated for this examination: ☐ No ☐ Yes, what did you take: _____
What other medications are you currently taking (include herbal and over the counter medications):

Medication	Reason	Dose	Taken How Often	Route

List any medication or food allergies and reactions: _____
_____
Have you ever had radiation or chemotherapy? ☐ No ☐ Yes, what type: _____ When: _____

PERSONAL HISTORY

Asthma	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes	Polycystic Ovary Disease	☐ No	☐ Yes
Bladder Disease	☐ No	☐ Yes	Liver Disease	☐ No	☐ Yes	Prostate Problems	☐ No	☐ Yes
Cancer	☐ No	☐ Yes	Multiple Myeloma	☐ No	☐ Yes	Respiratory Disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Heart Disease	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Dizziness	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	Seizure Disorder	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Implantable Device	☐ No	☐ Yes	Sickle Cell	☐ No	☐ Yes

If you answered "yes" to any of the above items, please explain: _____
_____

I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time.

_____ _____ _____/_____/_____ _____
Signature of Patient or Representative | Relationship to Patient, if Representative | Date | Time

Reviewed by:

_____ _____ _____/_____/_____ _____
Technologist/Radiation Therapist's Signature/Title | Print Name | Date | Time

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AINFO

X PATIENT NAME: _____

X DATE OF BIRTH: _____

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X_____ X_____ X_____/_____/_____ X_____

Signature of Patient or Representative | Relationship to Patient, if Representative | Date | Time

Reviewed by:

_____ _____ _____/_____/_____ _____

Technologist/Radiation Therapist's Signature/Title | Print Name | Date | Time