

I-Imaging

CT, IVP PROCEDURE QUESTIONNAIRE

PATIENT NAME _____ PATIENT # _____

EXAM ORDERED _____ REFERRING PHYSICIAN _____

SYMPTOMS _____ AGE _____

SEX | M | F

CIRCLE ONE

- | | |
|---|--|
| Y N ASTHMA/ HAYFEVER | Y N HYPERTENSIVE RENAL DISEASE (KIDNEY) |
| Y N CONGESTIVE HEART FAILURE | Y N MULTIPLE MYELOMA |
| Y N DIABETES | Y N RENAL FAILURE (KIDNEY) |
| Y N DO YOU TAKE GLUCOPHAGE, METFORMIN,
GLUCOVANCE OR AVANDAMET ? | Y N RESPIRATORY FAILURE |
| Y N FIBRILLATION OR HEART FLUTTER | Y N SICKLE CELL DISEASE |
| Y N HIGH BLOOD PRESSURE | Y N STROKE |
| Y N HEART DISEASE/ PROBLEMS | Y N ANGINA(SEVERE PAIN IN THE CHEST) |
| Y N GENERALIZED SEVERE DEBILITATION | Y N ARE YOU NURSING A BABY? |

IF YES DESCRIBE: _____

PLEASE LIST ALL ALLERGIES BELOW

1. _____ 3. _____
2. _____ 4. _____

PLEASE LIST ALL MEDICATIONS

1. _____ 3. _____
2. _____ 4. _____

PLEASE LIST ALL SURGERIES

1. _____ 3. _____
2. _____ 4. _____

HAVE YOU HAD PREVIOUS CT, XRAYS, OR MRI RELATED TO THIS PROBLEM?

IF YES, WHEN & WHERE: CT _____

XRAYS _____ MRI _____

PATIENT'S INITIALS _____ LAST MENSTRUAL PERIOD _____

TECHNOLOGIST USE ONLY:

Patient Status: Debilitated or Ambulatory BP: _____ WT: _____
Was the patient pre-medicated YES NO Fasting? YES NO
Contrast injected: _____ Lot# _____ Exp Date: _____
Volume: _____ ml Time: _____ Injection Site: _____
Technologist _____ Radiologist: _____
Additional Notes: _____