

IMAGECARE LLC
C.A.T. SCAN PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Weight: _____

Please place a check mark by the appropriate answer.

Is there any possibility you could be pregnant? Yes _____ No _____
If yes, please notify our staff immediately.

Do you have any Allergies? Yes _____ No _____
If yes, please list them: _____

Do you have a history of any of the following?

Kidney Disease	Yes _____	No _____
Asthma	Yes _____	No _____
Heart Disease	Yes _____	No _____
Sickle Cell Disease	Yes _____	No _____
Hypertension (high blood pressure)	Yes _____	No _____
Diabetes	Yes _____	No _____

If yes to diabetes, what medications do you take: _____

Last dose taken of this medication: Date: _____ Time: _____

THE INFORMATION BELOW WILL BE COMPLETED BY THE TECHNOLOGIST

Any previous history of reaction to I.V. Contrast? Yes _____ No: _____
If yes, describe reaction: _____

Any previous surgery to the same area being scanned today: Yes _____ NO _____
If yes, what type of surgery? _____

List pertinent history/symptoms: _____

Type of Contrast Isovue: 370 300 _____ cc's / Saline Flush: _____ cc's 0.45% or 0.9%
I.V. Site: _____ BUN: _____ / Creat: _____ / EGFR: _____

Patient Signature: _____ Date: _____

Technologist: _____ Date: _____

ImageCare is pleased to provide our patients with a CD of their images at NO charge initially. Do not return this CD. It is your property to keep as part of your medical record. However, if you require an ADDITIONAL CD of the same images in the future, you will be asked to pay \$20.00.

Did your physician request a CD: ___ Yes ___ No **Initials:** _____