GENERAL LEONARD WOOD

RADIOLOGY

ARMY COMMUNITY HOSPITAL

CT PATIENT HISTORY QUESTIONNAIRE

PATIENT NAME:_____ SPONSOR'S LAST 4 SSN:_____
DOB: __/__/__ AGE: _____ (if ≥ 40years need lab) BUN____ CREAT____ DATE:_____

WEIGHT: _____ PREGNANT: Y N

REASON FOR EXAM:_____

PRIOR SURGERY: (CIRCLE all that apply)
GALL BLADDER BOWEL BRAIN LUNG PROSTATE/HYST KIDNEY APPENDIX HEART
OTHER/COMMENTS:_____

HAVE YOU EVER HAD A CT EXAM REQUIRING CONTRAST DYE? Y N
DO YOU HAVE A HISTORY OF REACTION TO CONTRAST DYE? Y N NA
IF YES, PLEASE DESCRIBE:_____
DO YOU HAVE A HISTORY OF DIABETES? Y N
ARE YOU CURRENTLY TAKING ANY MEDICATION FOR DIABETES (Glucophage, Metformin, Glucovance, Metaglip, Avandamet, etc)?_____>>>YOU MAY BE ASKED NOT TO TAKE MEDICATION FOR 48 HOURS AFTER EXAM
ANY QUESTIONS PLEASE ASK..MAY BE ASKED TO CONFIRM WITH PROVIDER<<<
ANY ALLERGIES_____
SICKLE CELL DISEASE/G6PD DEFICIENCY ANY BLOOD DISORDER…Y…N

DO YOU HAVE:

ASTHMA Y N
HAY FEVER Y N
LUNG DISEASE Y N
EMPHYSEMA Y N
SHORTNESS OF BREATH Y N
COPD Y N
HIVES Y N
HISTORY OF SMOKING Y N

HEART FAILURE Y N
ARRHYTHMIA Y N
AORTIC STENOSIS Y N
CABG Y N
ANGINA Y N
HEART ATTACK Y N
PULMONARY HYPERTENSION Y N

KIDNEY DISEASE Y N
KIDNEY SURGERY Y N
KIDNEY TUMORS Y N
KIDNEY TRANSPLANT Y N
DIALYSIS Y N

MULTIPLE MYELOMA Y N
HIGH BLOOD PRESSURE Y N
CHEMOTHERAPY Y N
RADIATION THERAPY Y N

I HAVE READ THIS FORM AND HAVE ANSWERED THE ABOVE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE.
PATIENT'S SIGNTURE: _____ TODAY'S DATE: _____

PHONE TO USED FOR CALL BACK:_____

TECHNOLOGIST'S COMMENTS

Examination Performed:_____

IV ORAL RECTAL (circle all that apply) Attach Contrast Sticker Here!

DOB: __/__/__ AGE: _____ (if > 40years need lab) BUN____ CREAT____ DATE:_____

Print Current LAB worksheet from CHCS and Scan into ISITE after verification of acceptable LAB values.

Circle and initial by CREAT- **LAB** values for verification before scanning into **ISITE.** LABS must be current (within 30 days for outpatient- **same day for Emergency Department.**

Was examination and contrast explained to patient? Y N

Needle Size:_____

Inserted By:_____

Location of IV:_____

Contrast Type (circle all that apply): ULTRAVIST 370 OPTIRAY 320 GASTROGRAPHIN

Time of Injection:_____ am / pm

Injection Rate:_____

Amount Given:_____

Infiltration: Y N

Comments/concerns:_____
_____
_____
_____

TECHNOLOGIST'S SIGNATURE:_____ DATE:_____