

**College Park Family Care Imaging Center- CT Assessment/Pre-Exam Interview**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Attempted Call: \_\_\_\_\_

Procedure: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

WT: \_\_\_\_\_ HT: \_\_\_\_\_ LMP: \_\_\_\_\_

Reason for Exam: \_\_\_\_\_

Prior Exams (Please include CT/MRI/Plain films) & Locations: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_

**Patient History**

**CT CAN NOT be performed if "Yes" is answered to double standard (\*\*) questions. All "Yes" single asterisk (\*) are to be referred to the radiologist.**

Yes	No	
		<b>**Pregnant LMP:</b>
		Have you had any studies using injected contrast media?
		Have you had any allergies/reactions? Specify:
		Do you have any allergies to latex or rubber products?
		Do you have asthma or pulmonary diseases?
		Do you have any heart disease (MI, Angina, CHF, Arrhythmias?)
		Do you have hypertension?
		<b>*Do you have artificial Heart Valves or Heart Stents?</b>
		Do you have pacemaker or pacemaker wires?
		<b>*Do you have diabetes?</b>
		<b>*If yes, what medication do you use? (Please circle)</b>
		<b>*Insulin                      Glucophage, Metformin                      Other oral medication</b>
		<b>*Do you have any kidney disease (one kidney, transplant, etc?)</b>
		Do you smoke?
		Do you have blood disorders (sickle cell, hepatitis, AIDS?)
		Do you, or have you ever had cancer? Type:
		Have you had a PET scan? If yes, when & where
		Multiple myeloma (cancer of the bone marrow)?
		Are currently or have you had a chemotherapy or radiation?
		Pheochromocytoma (Tumor of adrenal medulla)?
		Neurological problems (seizure disorder, stroke, brain tumor)?
		Have you had any previous surgeries? Please list:
		Recent Trauma(s) including description and date of occurrence:
		Are you currently taking any medications? List:

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**AREA BELOW FOR OFFICE USE ONLY:**

Date interview was completed: \_\_\_\_\_ Person taking history: \_\_\_\_\_

**\*If history was taken 48 hours prior to exam history MUST be reviewed the day of the exam:**

Date: \_\_\_\_\_ Technologist reviewing history: \_\_\_\_\_

**If patient was premedicated, verify patient followed pre-medication instructions.** \_\_\_\_\_

IV Contrast:

IV Contrast: \_\_\_\_\_ Lot#: \_\_\_\_\_ Amount: \_\_\_\_\_

Injection Site: \_\_\_\_\_ Needle Gauge size: \_\_\_\_\_ Injected by: \_\_\_\_\_

Oral contrast: \_\_\_\_\_

Labs: Date of labs: \_\_\_\_\_

**BUN:** \_\_\_\_\_ **CR:** \_\_\_\_\_

Comments:

Reading Physician: \_\_\_\_\_

If pt was on Glucophage/Metformin, did they receive aftercare instructions? Yes No \_\_\_\_\_ Tech initials

Female patients shielded during exam Yes No