

CT INTERVIEW FORM

PATIENT NAME: _____

DATE OF BIRTH: DD/MM/YYYY AGE: _____ WEIGHT: _____

EXAMINATION: _____

Female Patients, is there a possibility that you could be pregnant?

NO	YES
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If YES, please inform the Radiographer NOW

GENERAL MEDICAL HISTORY

Reason(s) for todays exam: _____

Do you have a history of Cancer? If so, what type? _____

Do you have any previous history of surgery? If so, what and when? _____

Any personal history of:

Asthma	<table border="1"><tr><td>NO</td><td>YES</td></tr></table>	NO	YES	Circulatory disease	<table border="1"><tr><td>NO</td><td>YES</td></tr></table>	NO	YES
NO	YES						
NO	YES						
Diabetes	<table border="1"><tr><td>NO</td><td>YES</td></tr></table>	NO	YES	Lung Disease	<table border="1"><tr><td>NO</td><td>YES</td></tr></table>	NO	YES
NO	YES						
NO	YES						
Hypotension	<table border="1"><tr><td>NO</td><td>YES</td></tr></table>	NO	YES	Heart Failure	<table border="1"><tr><td>NO</td><td>YES</td></tr></table>	NO	YES
NO	YES						
NO	YES						
Hypertension	<table border="1"><tr><td>NO</td><td>YES</td></tr></table>	NO	YES	Renal Insufficiency	<table border="1"><tr><td>NO</td><td>YES</td></tr></table>	NO	YES
NO	YES						
NO	YES						

Have you had any kidney surgery or kidney disease, or any family history of kidney failure?

NO	YES
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If YES, specify: _____

Have you had or are you being evaluated for solid organ transplant? (Liver, Kidney, Heart)

NO	YES
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If YES, specify: _____

Are you on or have you had chemotherapy within the last month?

NO	YES
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If YES, specify: _____

Have you had any Barium studies recently?

YES	NO
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If YES, specify: _____

Are you allergic to anything?

YES	NO
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If YES, specify: _____

Have you ever had a reaction to Intravenous X-Ray dye?

YES	NO
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If YES, specify: _____

What medication are you taking at present? _____

I, _____ (Patient's Full Name) hereby consent to the injection of IV (intravenous) contrast and that the possible side effects of this contrast media injection has been fully explained to me.

PATIENT SIGNATURE: _____

DATE: DD/MM/YYYY

RADIOGRAPHER SIGNATURE: _____