Lexington Clinic
Since 1920

CT/IVP HISTORY AND SCREENING

Patient Name:_____ Date:_____

Date of Birth:_____ Patient Weight:_____

Briefly describe the problem you are having:_____

_____

_____

Have you had any previous CT, MRI and/or IVP exam(s) for this problem? If so, when and where?_____

List any surgeries you have had:_____

_____

Do you have or have you ever had any of the following? (Place a √ if yes.)

- ☐ Allergic reaction to iodine
- ☐ Allergic reaction to contrast (x-ray dye)
- ☐ Allergic reaction to seafood/shellfish
- ☐ Food allergies (list):_____
- ☐ Seasonal allergies
- ☐ Asthma
- ☐ Diabetes
- ☐ Renal failure
- ☐ Kidney condition
- ☐ Cardiac pacemaker
- ☐ Implantable cardiac defibrillator
- ☐ High blood pressure
- ☐ Pulmonary hypertension
- ☐ Heart failure
- ☐ COPD/emphysema
- ☐ Recent acute heart attack
- ☐ Abnormal heart beats such as severe arrhythmias, dysrhythmias
- ☐ Severely debilitating condition(s)
- ☐ Sickle-cell anemia
- ☐ Multiple myeloma
- ☐ Pheochromocytoma (adrenal tumor)
- ☐ Severe thyrotoxicosis (highly overactive thyroid)
- ☐ Thyroid condition
- ☐ Currently breast feeding
- ☐ Cancer; (if yes, what type): _____
- ☐ Smoking history (for CT only): number of years_____; packs/day_____

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form.

Patient Signature:_____ Date:_____

CT Technologist's comments:_____

_____