CT Patient Screening Form

Height: _____ **Weight:** _____

1. Do you have history of Diabetes? Yes No
2. Do you take any Diabetes Medications? Yes No

   If yes, what type (circle)

Metformin	Glumetza	Glucovance
Glucophage	Fortamet	Actoplusmet
Glucophage XR	Riomet	Avandamet

3. Do you have a history of Asthma? Yes No
4. Do you have a history of Cancer? Yes No

   If yes, what type? _____

   What year was it diagnosed? _____

   What type if treatment have you had? _____
5. Do you have a history of Kidney Disease? Yes No
6. Do you have a history of Multiple Myeloma? Yes No
7. Do you have a history of Pheochromocytome? Yes No
8. Do you have a history of Polycythemia? Yes No
9. List any previous surgeries: _____
10. List any medications you are allergic to: _____
11. Have you had any radiology exams at this facility? Yes No

    If yes, what year? _____
12. Why are you having this CT examination? (Please be specific and list all of your symptoms)

_____

_____

_____

Patient/Legal Guardian Signature Date Time

_____

Technologist's Signature Date Time

**********Official Use Only**********

Bun Creatinine GFR Radiologist Signature _____