Southern Diagnostic Imaging Center

Computed Tomography Screening Form

NAME_____ WEIGHT_____

What are your symptoms? _____

_____

MEDICAL HISTORY: (check all that apply)

__ Kidney Disease/Failure __Asthma __High Blood Pressure __ Diabetes __Heart Disease

__History of Cancer Type: _____

Chemo: Y or N Rad. Therapy: Y or N

Do you have any drug allergies? Y or N If yes, please list: _____

_____

Please list ALL surgeries (if applicable): _____

_____

_____

List ALL medications you are currently taking: _____

_____

FEMALE PATIENTS ONLY:

Are you pregnant or do you suspect you are pregnant? Y or N
Are you breast feeding? Y or N

Date of last menstrual cycle if not post-menopause_____

FOR OFFICE USE ONLY:

BUN _____
CRE _____

ADVERSE REACTION DOCUMENTATION: _____

_____

_____