CT Information Form

Patient Name: ________________________ **DOB:** _________ **Sex:** _________ **Weight:** ________

Reason for Exam:

____

____

____

	Yes	No	Comments
Has exam been done previously for this condition?			
Have you had any surgeries?			
Have there been any previous injuries to the affected area?			
Do you have any food or medication allergies?			
Do you have any history of smoking?			If yes, how many packs per day?
Do you have any history of cancer?			
Have you ever had a previous injection with contrast material?			If yes, did you have a reaction? ___Yes ___ No
Have you had anything to eat or drink today?			If yes, what and how long?
Are you pregnant?			

Patient Signature: ____ Date: ____________________

Technologist Signature: ____ Date: ____________________