CT and IV Contrast History and Screening Form

Patient Name: _____ DOB: _____

Age: _____

Allergies: _____

Have you ever had a reaction to iodine or x-ray contrast? Yes No

If yes, please explain: _____

Surgeries: _____

Pregnant: Yes No

Any personal history of:

Asthma Yes No

High Blood Pressure Yes No

Diabetes Yes No

What type of medication do you take for your diabetes? _____

Kidney Disease Yes No

Dialysis? What days? _____

Multiple Myeloma Yes No

Cancer Yes No

If yes, what form and have you had any treatment: _____

Symptoms: _____

_____

For Technologist Use Only

Labs: Creatinine: _____ **GFR:** _____ **Date:** _____ **I STAT**

Oral Start Time: _____

Omnipaque _____/_____ cc Lot Number _____ _____ GA IV in the _____

Contrast Reaction: Yes No Technologist _____