

INSTRUCTIONS: Please complete this Patient History & Contrast Worksheet to the best of your ability.

Your Name: _____ DOB: _____ Today's date: _____

For each of the following questions, please check Yes or No:

Have you had any symptoms related to the current problem? YES NO

If YES list the symptoms related to your current problem: _____

_____ Date symptoms began: _____

Have you had any tests related to the current problem? YES NO

If YES list tests, date, and location they were completed: _____

Are you having this exam because of a recent or past injury (Trauma)? YES NO

If yes, what was the injury? _____ Date of injury? _____

Have you had any surgeries? YES NO

If YES type of surgery/date: _____

Do you have/or have you had Cancer? YES NO

If Yes, what type: _____ Body part affected: _____

Type of cancer treatment: _____ Still undergoing treatment? YES NO

Do you currently or have you ever smoked? YES NO

If YES, how many years? _____ Packs per day? _____

Have you had a previous reaction to iodinated contrast? YES NO

Have you ever had a life-threatening reaction to medication or food? YES NO

If YES, to what: _____

For women of childbearing age: Is there a possibility that you may be pregnant? YES NO

Currently breastfeeding? YES NO

Do you have any Kidney Problems? YES NO

If YES explain: _____

Do you have Diabetes? YES NO

If YES, are you taking Glucophage / Metformin? YES NO

Have you had a prior CT Scan? YES NO

If YES, what body part, date, and location it was completed: _____

Signature _____ Date _____ Time _____
Patient or Guardian

This Section for Staff Use Only - Contrast and Technologist Information: (Required)

Tech: _____ / ____ / _____ Tech: _____ / ____ / _____
Signature Date Time Signature Date Time

Contrast Agent Used: _____ Volume Injected (mL) _____

Post-procedure Metformin instructions given if patient with eGFR < 30mL/min/1.73m2 indicated Metformin is used

eGFR within past 30 days for outpatients with renal impairment and within 72 hours for inpatients

Contrast Information is complete

Post-procedure Patient Condition: Good Complication, (explain): _____

Evidence of Contrast Reaction YES NO If YES, RN Notified _____

Imaging Services Patient History & Contrast Worksheet

MNM 721.159



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