

Woodlands Imaging ♦ 1960 Digital Imaging ♦ I-Imaging

CT, IVP PROCEDURE QUESTIONNAIRE

PATIENT NAME _____ PATIENT # _____

EXAM ORDERED _____ REFERRING PHYSICIAN _____

SYMPTOMS _____ AGE _____

SEX M F

CIRCLE ONE

- | | |
|--|--|
| Y N ASTHMA/ HAYFEVER | Y N HYPERTENSIVE RENAL DISEASE (KIDNEY) |
| Y N CONGESTIVE HEART FAILURE | Y N MULTIPLE MYELOMA |
| Y N DIABETES | Y N RENAL FAILURE (KIDNEY) |
| Y N DO YOU TAKE GLUCOPHAGE, METFORMIN, GLUCOVANCE OR AVANDAMET ? | Y N RESPIRATORY FAILURE |
| Y N FIBRILLATION OR HEART FLUTTER | Y N SICKLE CELL DISEASE |
| Y N HIGH BLOOD PRESSURE | Y N STROKE |
| Y N HEART DISEASE/ PROBLEMS | Y N ANGINA(SEVERE PAIN IN THE CHEST) |
| Y N GENERALIZED SEVERE DEBILITATION | Y N ARE YOU NURSING A BABY? |

IF YES DESCRIBE: _____

PLEASE LIST ALL ALLERGIES BELOW

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

PLEASE LIST ALL MEDICATIONS

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

PLEASE LIST ALL SURGERIES

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

HAVE YOU HAD PREVIOUS CT, XRAYS, OR MRI RELATED TO THIS PROBLEM?

IF YES, WHEN & WHERE: CT _____

XRAYS _____ MRI _____

PATIENT'S INITIALS _____ LAST MENSTRUAL PERIOD _____

TECHNOLOGIST USE ONLY:

Patient Status: Debilitated or Ambulatory BP: _____ WT: _____

Was the patient pre-medicated YES NO Fasting? YES NO

Contrast injected:	Lot#	Exp Date:	
Volume:	ml	Time:	Injection Site:
Technologist	Radiologist:		
Additional Notes:			