MONROE SURGICAL HOSPITAL

CT SCREENING FORM

(revised 03/27/2017)

For XRAY Use Only:

☐ Name Verified_____(initials)

☐ Date of Birth Verified_____(initials)

Patient's Name:_____

Date of Birth:_____

Height:_____ **Weight:**_____

What are your symptoms?

_____

_____

Have you ever had a CT? _____ Yes _____ No

Were you given IV dye (contrast)? _____ Yes _____ No _____ Don't Know

Are you allergic to Iodine? _____ Yes _____ No _____ Don't Know

Medical History: (Check those that apply)

___ Kidney disease ___Asthma ___ High Blood Pressure

___ History of Cancer ___ Diabetes Medication for Diabetes:_____

Please list all drug allergies:

_____

_____

Please list all previous surgeries:

_____

_____

For Female Patients Only:

Are you pregnant or do you suspect you could be pregnant? Yes No

Are you breast feeding? Yes No

Date of last menstrual cycle, if not post-menopause:_____

By my signature, I do attest that the above information is correct as given.

_____ _____

Patient/Legal Guardian's Signature Date