

**MONROE SURGICAL HOSPITAL
CT SCREENING FORM**

(revised 6/17/2011 sc)

For XRAY Use Only:

- Name Verified _____ (initials)
- Date of Birth Verified _____ (initials)

Patient's Name: _____

Date of Birth: _____

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, if so, medication _____

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