TOWER RADIOLOGY

# CT SAFETY QUESTIONNAIRE

Name: _____ DOB: _____ Height: ____ Weight: ____

Date: _____ Referring Doctor? _____

1. What complaints/symptoms led you to see the doctor? _____
   Duration of symptoms _____

| | | | |
|---|---|---|---|
| 2. Diabetes | Yes | No | Diabetic medication_____ How long__ |
| Do you take metformin? | Yes | No | Date last taken: _____ |
| 3. Kidney Disease | Yes | No | |
| Dialysis | Yes | No | Next Dialysis _____ |
| Pheochromocytoma | Yes | No | |
| 4. Cardiac Problems | Yes | No | Medications: _____ |
| Stroke | Yes | No | |
| 5. Personal Cancer History | Yes | No | Type and date diagnosed _____ |
| Chemo | Yes | No | Date of last treatment _____ |
| Radiation | Yes | No | Date of last treatment _____ |
| 6. Multiple Myeloma | Yes | No | |
| 7. Weight loss | Yes | No | Amount ___lbs. Time frame _____ |
| 8. Respiratory Problems | Yes | No | Please circle: Asthma Emphysema Bronchitis |
| History of smoking | Yes | No | |
| 9. Alcohol Consumption | Yes | No | |
| 10. High Blood Pressure | Yes | No | |

11. Please list ALL prior surgeries and dates:

_____

_____

12. Please list all other medications:

_____

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# ALLERGY HISTORY

1. Personal Allergy History: Please indicate type of reaction (severity) and treatment if any.

Medications_____

Food_____

Environmental Agents_____

2. Previous injection of x-ray dye for exams such as Angiogram, IVP or CT?

YES NO

Any reaction or problems after receiving dye?_____

3. Any history of kidney disease or dialysis? If yes, explain:_____
_____

***Please indicate if you have or take an inhaler for any medical reason.**

YES NO Do you have the inhaler here with you today?_____

# CONSENT FOR CT/MRI CONTRAST AND PROCEDURE

Patient Name_____

I understand the CT/MRI Scan may require an injection of contrast material. The risks of having a contrast reaction were discussed and noted to include, but are not limited to, various types of allergic reactions. Most of these reactions are minor, although they can be severe at times. On rare occasions, inflammation or infection at the site of injection can occur. Very rarely complications can be so severe death can occur.

I acknowledge that all risks of the CT scan and the injection required for my study have been explained to me. I authorize Tower Radiology, LLC to perform the indicated CT study and to inject the contrast medium needed for my exam.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Signature of Technologist Date

_____ _____
Signature of Radiologist Date

**Contrast Information**

Lot # _____ Expiration_____ Amount_____
Tech_____Complications_____

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