CT Patient Screening

Please Answer the Questions Below Yes or No

1. Do you have history of Diabetes? ___Yes ___No
2. D you take any Diabetes Medicine? ___Yes ___No
   If yes, what type (circle)

Metformin	Glumetza	Glucovance
Glucophage	Fortamet	Actoplusmet
Glucophage XR	Riomet	Avandamet

3. Do you have a history of Asthma? ___Yes ___No
4. Do you have a history of Cancer? ___Yes ___No
   If yes, what type? _____
   What year was it diagnosed? _____
   What type of treatment have you had? _____
5. Do you have a history of Kidney Disease? ___Yes ___No
6. Do you have a history of Multiple Myeloma? ___Yes ___No
7. Do you have a history of Pheochromocytoma? ___Yes ___No
8. Do you have a history of Polycythemia? ___Yes ___No
9. List any previous surgeries: _____
10. Please list any medicines you are allergic to: _____
11. Have you had any radiology exams at this facility? ___Yes ___No
    If yes, what year: _____
12. Why are you having this CT examination? (please be specific and list your symptoms)
    _____
    _____

_____ _____ _____
Patient/Parent/Legal Guardian Signature Date Time

_____ _____ _____
Witness Signature Date Time

**********OFFICIAL USE ONLY**********

BUN _____ Creatinine _____ GFR _____

_____
Radiologist Signature