RADNET MANAGEMENT, INC.

FACILITY: ______________________________

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History Form

FORM.POL.002
Effective Date: July 15, 2013

CT SCAN PATIENT HISTORY

Date: ____________________ Height: ____________ Weight: ______________

Name: ____ Age: ________________

1. Please list any symptoms you currently have which you feel are related to your problem (i.e. pain, nausea, weight loss, etc.): ____
____
2. Have you had any other tests related to this problem (i.e., Lab, X-Ray, Barium Enema, UGI, Ultrasound, MRI, previous CT)? ☐YES ☐ NO If yes, what test? ______________________________
____
3. Please list any surgeries you have had and what they were for: ______________________________
____
4. Please list any medication you are taking and what it is for: ______________________________
____
5. Do you have any electronic medical devices? ☐YES ☐ NO
Cardiac Pacemakers, Implantable Cardiac Defibrillators, Neuro-stimulator, Drug Infusion Pumps, including Insulin Pumps, Cochlear implants and Retinal Implants:
____
6. Do you currently have cancer or have you had cancer? ☐YES ☐ NO
If yes, what part of your body was affected? ______________________
What type of treatment did you receive? ______________________
____
Are you finished with treatment? ☐YES ☐ NO
7. Are you or is there a possibility you could be pregnant? ☐YES ☐ NO
8. Please indicate whether you have a history of any of the following:
(Please answer all questions):

☐ YES ☐ NO Allergies? If yes, what type? ______________________

☐ YES ☐ NO Asthma?

☐ YES ☐ NO Kidney failure?

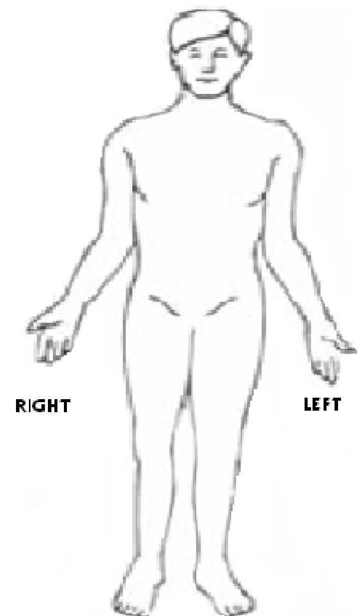
☐ YES ☐ NO Heart disease?

☐ YES ☐ NO Diabetes?

☐ YES ☐ NO Insulin dependent?

☐ YES ☐ NO Reaction to x-ray contrast?

☐ YES ☐ NO Sickle Cell Anemia?



Please use the diagram above to show where you think your problem is located or where you have pain.

TECHNOLOGIST'S NOTES:
Documentation of electronic devices:
☐No electronic devices ☐Electronic device present
How it was handled: ____

COMMENTS: ____
____

INJECTION INFORMATION:
I.V. Site: ____

Type: ☐ Butterfly ☐ Angiocath Contrast Used: ______________________________

Amount: __________cc ☐ Bolus ☐ Infusion ☐ Power Injection Infiltration: ☐ Yes ☐ No Amount: __________cc

Patient Response: ____

Injected by: ____