Place Patient Label Here

CT Patient History

Oregon Medical Group Imaging
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Eugene, Oregon 97401
(541) 242-4162 • Fax (541) 345-2358

Patient Name _____

DOB _____ Date _____

Primary Care Physician _____

1. Reason for this exam? (e.g. headaches, low back pain, injury) _____

_____

2. Have you ever had contrast material (dye) injected for IVP (kidney x-ray), CT scan, venogram, or angiogram? ☐ **Yes** ☐ **No**

3. Is there a possibility you are pregnant? ☐ **Yes** ☐ **No**

4. Do you have:

Yes	No		Yes	No	
☐	☐	Allergies (Iodine, food or medicine)	☐	☐	Diabetes
☐	☐	Asthma	☐	☐	Kidney Problems
☐	☐	Hay fever	☐	☐	Multiple myeloma
☐	☐	Difficulty breathing	☐	☐	Sickle cell disease
☐	☐	High blood pressure	☐	☐	Pheochromocytoma
☐	☐	Heart problems			

5. Are you taking Metformin? ☐ **Yes** ☐ **No**

6. Have you had a prior exam, in the area of concern? ☐ **Yes** ☐ **No**

When?	Where was it done?	What kind? (CT, MRI, Myelogram, etc)

7. Have you ever had any surgery in the area of concern? ☐ **Yes** ☐ **No**

When & Where?	Location / Level	Reason?

8. By signing below, you acknowledge that you have read and understand this questionnaire.

_____ SIGNATURE

_____ DATE

DO NOT WRITE IN SHADED AREA

Tech notes _____

IV Contrast _____ cc of _____

Oral Contrast _____

Radiologist

_____