



Rockledge MRI & PET Imaging Center

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CT Clinical

Patient Name _____ Patient # _____

Previous surgery on area of scan? YES / NO If yes, what type? _____

Previous trauma/accident? YES / NO Duration? _____ Type of injury? _____

Have you ever been diagnosed with cancer? YES / NO Type _____ Year _____

Body Part _____ Treatment SURGERY / RADIATION / CHEMO THRAPY

- Have you ever had a previous contrast reaction? YES / NO _____
- Are you 60 or older? YES / NO _____
- Are you allergic to iodine / shellfish? YES / NO _____
- Are you allergic to latex? YES / NO _____
- Are you diabetic? YES / NO _____
- Are you taking any medication for diabetes? YES / NO _____
- Have you ever had kidney disease/renal failure? YES / NO _____
- Are you pregnant or breastfeeding? YES / NO _____
- Are you on dialysis? YES / NO _____

CREATININE RESULTS _____ RANGE _____ - _____ TEST DATE _____

PRIOR STUDIES:

Scan Type: _____ Area _____ Facility _____ Date _____
 Scan Type: _____ Area _____ Facility _____ Date _____
 Scan Type: _____ Area _____ Facility _____ Date _____

Staff Initial _____

Patient's Signature _____ Date _____