Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

CT and IV Contrast History/Screening Form

Patient Information

Patient Name _____ Date _____

DOB: _____ Age:_____ Ht: _____ Wt:_____ Sex: ☐ M ☐ F

Are You Pregnant? ☐ YES ☐ NO Last Menstrual Cycle: _____

Who Ordered this Exam? _____

Have you had a previous exam related to this problem? ☐ YES ☐ NO

If YES, what type of Exam? ☐ CT ☐ MRI ☐ Bone Scan Where? _____ When? _____

List other Medical Problems _____

List Previous Surgeries_____

_____

Medications presently taking _____

_____

Allergies_____

Contrast History ☐ **Not applicable to this Exam**

Are you taking Glucophage? ☐ YES ☐ NO BUN_____ CREATININE _____

Have you ever had a previous allergic reaction to X-ray Contrast (Dye)? ☐ YES ☐ NO

If YES, explain:_____

Personal History - Please Check If you Have or Have Had Any of the following:

☐ **Asthma**	☐ **Cancer**	☐ **Seizure Disorder**
☐ **Diabetes**	☐ **Kidney Disease**	☐ **Chronic Headaches**
☐ **Dizziness**	☐ **Stroke**	☐ **Heart Disease**
☐ **Liver Disease**	☐ **Allergic Respiratory Disease**	☐ **Breast Feeding at this Time**

If you checked any, please explain _____

_____

I have answered these questions to the best of my knowledge and understand the information provided to me. I have also informed the technologist that I am not pregnant at this time.

_____ _____

Patient Signature Date

_____ _____

Tech Signature Date

Office Use Only

Type of Contrast_____ Mfg _____

Time of Injection _____ Amount _____ Location Given _____

Lot Number_____ Expiration date _____