

Radiology Associates of Ridgewood, P.A.

COMPUTED TOMOGRAPHY

Name _____ Date _____

Age: _____ Date of Birth: _____ Wt: _____ Ht: _____

REASON FOR EXAMINATION / YOUR CHIEF COMPLAINT: _____

PLEASE CHECK APPROPRIATE ANSWER

Allergies:	Yes	No
X-ray Dye	<input type="checkbox"/>	<input type="checkbox"/>
★ If yes, were you premedicated today?	<input type="checkbox"/>	<input type="checkbox"/>
History of severe allergy/Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Food / Medication _____	<input type="checkbox"/>	<input type="checkbox"/>

Personal Medical History:	Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Failure / Disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease / Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Myeloma	<input type="checkbox"/>	<input type="checkbox"/>
Connective Tissue Disease (Rheumatoid Arthritis, Scleroderma, Lupus, Dermatomyositis, Sarcoidosis)	<input type="checkbox"/>	<input type="checkbox"/>

Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Arrythmia	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker / Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____		
Radiation or Chemo Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Pheochromocytoma	<input type="checkbox"/>	<input type="checkbox"/>
Insulinoma	<input type="checkbox"/>	<input type="checkbox"/>
Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>

1. List all previous surgery: _____

2. List all other medications you are presently taking:

3. Do you take Aspirin or NSAIDS daily? Yes No

4. Have you ever had an injection of x-ray dye? Yes No
 ★ If yes, did you have a reaction? Yes No

5. Have you had injection of x-ray dye within the past 30 days? Yes No

6. Is there any possibility you are pregnant/breastfeeding? Yes No
(females between 12-52) Unsure

Last menstrual period: _____

Signature _____

7. Smoking History current former never

a) _____ packs per day _____ number of years smoking/smoked

b) If former smoker, how many years since quitting? _____ years

FOR OFFICE USE ONLY: Creatinine _____	GFR _____
Normal Range (0.6 - 1.3 mg/dl)	Normal Range (>60)
Acceptable Range (<2.0 mg/dl)	Acceptable Range (>30)

Injection

Site: _____ Lot: _____

Amount: _____ Exp: _____

Rx and history reviewed by: _____