Maximum Resolution Imaging
THE NEW ERA OF IMAGING
www.maxresolutionimaging.com

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CT and IV Contrast History and Screening Form

Patient Name _____ Date _____
Date of Birth _____ Age _____ Weight _____

Sex Male / Female
What is the reason for the CT today
_____
_____
_____
Have you had any previous X-Rays, MRIs, CTs, or Ultrasounds? Yes / No
If yes : What _____ When_____
Where_____

IV Contrast History:

Asthma and/or allergic respiratory disease? Yes / No

Do you smoke? Yes / No

Diabetes? Yes / No
If yes, do you take oral medication containing Metformin? Yes / No

Glucophage / Metaglip /Avandamet / Riomet / Fortamet / Glucovance

Kidney disease? Yes / No

Heart disease? Yes / No

Stroke? Yes / No

Liver disease? Yes / No

Seizure disorder? Yes / No

Thyroid disorder? Yes / No

Blood thinner? Yes/ No

If yes, what type? _____

Cancer? Yes/ No
If yes, what type? _____
Radiation therapy: Yes/ No Chemotherapy: Yes/ No

Are you pregnant? Yes/ No Date of last menstrual period _____

Are you currently breast feeding? Yes/ No

List all previous surgeries:
_____
_____
_____

List all medications you take regularly:
_____
_____
_____
List any drug allergies:
_____
List any food allergies:
_____
Have you ever had an allergic reaction to x-ray contrast (IODINE DYE)? Yes / No
If yes, please explain:
_____
_____

IV Contrast Consent

CT/MRI examinations often require the use of contrast materials to enhance the visibility of certain tissues or blood vessels. The contrast material may be given as something to drink before your exam, or injected intravenously during your exam. The intravenous contrast material contains IODINE and some people may be allergic. We screen all of our patients for this prior to administrating the intravenous contras material. We use non-ionic contrast material which is proven to be more tolerable. Some reactions such as nausea, vomiting, skin rash, or other more severe reactions can occur, but are more uncommon. With the safety of the new non-ionic contrast material, adverse effects are very rare.

I attest that the information is correct to the best of my knowledge. I have read and understood the entire contents of this form. I also understand the procedure, risks and possibilities of complications. I give my permission for oral and/or IV contrast solution to be given if necessary and I have had the opportunity to ask questions regarding the information on this form.

Patient's, parent or guardian signature _____ Date _____

Print patient's name _____

Witness Signature _____Date _____

Stop Here- To be completed by the technologist

Technologist Reason for exam

_____

Pertinent history

_____

Oral contrast given _____ Amount _____

IV contrast given Contrast type/Lot # _____ Amount _____ (CCs)

Needle gauge _____ IV site _____

BUN _____ Creatinine _____ Date drawn _____

Contrast allergy: Yes / No Patient premedicated for exam: Yes / No
Contrast reaction: Yes / No Discharge instructions given for contrast reaction: Yes / No
Discharge instructions given for Glucophage/Glucovance/Metformin Yes / No
Additional Comments:

_____

_____

_____

_____