

Patient Name:

Date of Birth:

Referring Physician:

Primary Care Physician:

Emergency Contact:

Phone Number:

Relationship:

CT Patient History

- Yes No Have you had bloodwork in the past 30 days?
Where? _____
- Yes No Are you diabetic?
- Yes No Do you take glucophage/metformin/glucoavance?
- Yes No Do you or have you ever had cancer?
- Yes No Is there a possibility that you might be pregnant or are you breast feeding?
- Yes No History of kidney failure, Renal Disease, or Renal Surgery?
- Yes No History of heart disease?
- Yes No Severe debilitation?
- Yes No History of sickle cell anemia?
- Yes No History of asthma?
- Yes No History of hay fever?
- Yes No History of unstable angina?
- Yes No History of recent heart attack?
- Yes No History of pulmonary hypertension?
- Yes No Have you ever had x-ray contrast?
- Yes No Any reaction to x-ray contrast?

History of severe arrhythmias such as:

- Yes No Ventricular tachycardia
- Yes No Sinoarterial dysfunction
- Yes No Heart block second or third degree

Symptoms and duration _____

Any allergies to medication or foods? _____

Please list any surgeries you have had: _____

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (Parent or Guardian)

Date Signed: _____