Rockledge MRI & PET Center

1910 Rockledge Blvd. Suite 102, Rockledge, FL 32955

CT CLINICAL INFORMATION & CONTRAST CONSENT FORM

Patient Name___________________________________M__ F__ Age_____Height:_______ Weight:________

When is your follow up appt. with your physician?____

For what reason do you believe you are having your exam? ____

____

How long have you had your symptoms? ____

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

Have you ever been diagnosed with cancer? YES/NO Type______________________Year_________________

Body Part__________________________ Treatment? (CIRCLE) SURGERY / RADIATION / CHEMO THERAPY

Do you have multiple myeloma? YES/NO __________________________________
Do you have hyperthyroidism? YES/NO __________________________________
Do you have any history of heart disease? YES/NO __________________________________
Any history of sickle cell anemia or blood disease? YES/NO __________________________________
Do you have a history of stroke,seizure,or brain tumor? 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 on dialysis? YES/NO __________________________________
Do you have a history of pheochromocytoma? YES/NO __________________________________
Have you ever had a CT scan with contrast? YES/NO __________________________________
Have you ever had a previous contrast reaction? YES/NO __________________________________
Do you have a history of asthma or hayfever? YES/NO __________________________________

Please list any substances to which you have had an allergic reaction and describe the symptoms for each reaction: ____

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____

Please list any current medications (if you have not presented a prepared list of medications). ___________________

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____

ARE YOU PREGNANT? (CIRCLE) **YES** **NO** **ARE YOU BREASTFEEDING?** YES/NO

PRIOR STUDIES (on area of interest) :
Scan Type_________ Area_________________ Facility_____________________ Date_________
Scan Type_________ Area_________________ Facility_____________________ Date_________
Scan Type_________ Area_________________ Facility_____________________ Date_________

Patient's Signature____Date____________________

CREATININE RESULTS_________ RANGE_______-_______ TEST DATE______________