DIAGNOSTIC RADIOLOGY CENTER OF THE TREASURE COAST, INC.
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BOARD CERTIFIED RADIOLOGIST

# CAT SCAN SCREENING FORM

PLEASE PROVIDE THE FOLLOWING INFORMATION. (PRINT CLEARLY)

NAME______________________________________ DATE__________________

DOB________________ AGE ________________

REFERRING PHYSICIAN_____________________________________________

REASON FOR EXAM (SYMPTOMS) ____________________________________

____________________________________________________________________

WHEN DID SYMPTOMS FIRST BEGIN?_________________________________

LIST SURGERIES YOU HAVE HAD______________________________________

____________________________________________________________________

PREVIOUS RADIOLOGY STUDIES ______________________________________

PRIOR IODINE INJECTIONS : YES NO
ANY ALLERGIC REACTIONS: YES NO
PRIOR CAT SCANS: YES NO

LIST ALLERGIES TO ANY MEDICATIONS/FOOD ________________________

ANY PERSONAL HISTORY OF THE FOLLOWING:
ASTHMA/HAYFEVER: YES NO HEART DISEASE: YES NO

HYPERTENSION YES NO D IABETES YES NO

GLUCOPHAGE YES NO RENAL DISEASE / KIDNEY FAILURE Y N
NEXT DIALYSIS TREATMENT__________________________________

CANCER YES NO WHAT AREA?________________________
CHEMO________________ RADIATION ______________

ANY POSSIBILITY OF BEING PREGNANT? YES NO
ARE YOU CURRENTLY BREAST FEEDING? YES NO