

CHEST, ABDOMEN/PELVIS HISTORY FORM

PATIENT NAME _____ AGE _____ BIRTHDATE _____

REFERRING PHYSICIAN _____ HEIGHT _____ WEIGHT _____ M F

SCAN # _____ TECH _____

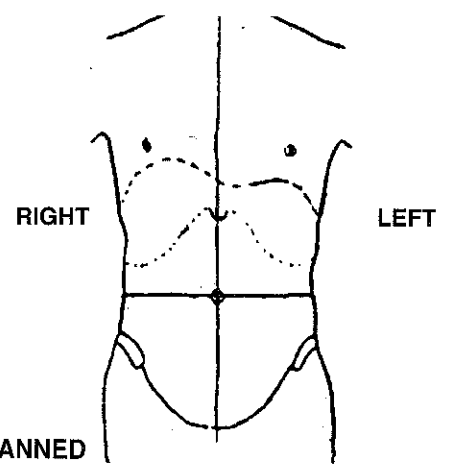
1. What is the main reason for having this scan? _____
2. How long have you had these symptoms? _____
3. Have you ever had an MRI, CT or XRAY of your:
 - Chest YES NO where & when _____
 - Abdomen/Pelvis YES NO where & when _____
4. Have you had any surgery on your:
 - Chest YES NO Type & Date _____
 - Abdomen/Pelvis YES NO Type & Date _____
5. Have you ever been diagnosed with cancer? YES NO
 If so, when and what type? _____
 What treatment did you receive? Surgery Radiation Chemotherapy None
6. Have you had a previous allergic reaction to MRI, CT or XRAY contrast? YES NO
 If so, explain _____
7. Are you Diabetic? YES NO
 If so, are you currently taking Metformin? YES NO
8. Have you had blood work in the last 30 days? YES NO where? _____
9. Traveled Recently? YES NO when/where? _____
10. Check any that apply and state the duration:

- | | |
|--|---|
| <input type="checkbox"/> Recent Weight Gain _____ | <input type="checkbox"/> Recent Weight Loss _____ |
| <input type="checkbox"/> Recent Constipation _____ | <input type="checkbox"/> Recent Diarrhea _____ |
| <input type="checkbox"/> Blood in Urine _____ | <input type="checkbox"/> Blood in Stool _____ |
| <input type="checkbox"/> History of Smoking _____ | <input type="checkbox"/> History of Kidney Stones _____ |

11. Shade in area of Pain on the Diagram

12. Female Patients

What date did your last menstrual period begin _____
 Any chance you could be pregnant YES NO
 Are you currently on birth control YES NO



IF YOU ARE PREGNANT PLEASE INFORM THE TECHNOLOGIST BEFORE BEING SCANNED

I am aware that there may be risks involved to my unborn child if exposed to either MR and/or CT examination. I accept full responsibility if any future complications should arise. To the best of my knowledge I am NOT pregnant. _____

INFORMED CONSENT

FOR NON-IONIC IODINATED INTRAVENOUS CONTRAST

You are scheduled for a computerized tomogram (CT or CAT scan). This test uses X-rays and computers to visualize your internal organs and tissues.

As part of your study today, you may receive a clear, non-ionic iodinated contrast media.

1. **Minor reactions:** Itching or an upset stomach which require no treatment.
The chance of a minor reaction is about 1 in 100 or 1%.
2. **Serious reactions:** These side effects of contrast media usually require medical treatment and can even cause harm. These include shortness of breath, irregular heartbeat, convulsions, kidney failure, or unconsciousness.
The chance of a serious reaction is about 1 in 6,000 or 0.017%.
3. **Death:** Rarely, as with many drugs, contrast media can cause death.
The chance of you dying from the injection of contrast media is about 1 in 100,000 or .000001%.

Please check if you have:

- | | |
|---|--|
| <input type="checkbox"/> Allergy to IODINE | <input type="checkbox"/> Allergy to shellfish (shrimp, lobster, etc) |
| <input type="checkbox"/> Known renal (kidney) failure | <input type="checkbox"/> Respiratory Deficiency |
| <input type="checkbox"/> Multiple myeloma | <input type="checkbox"/> Cardiac Complications |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Are you taking METFORMIN/GLUCOPHAGE? |

Yes _____ No _____ I have read the above information and have had my questions answered.
If you have any questions, please ask the technologist or the attending Radiologist.

I agree to have intravenous non-ionic iodinated contrast media.

Signature

Witness / Date

Parent / Guardian If the patient is a minor or is unable to sign

Witness / Date