ATLANTIC
RADIOLOGY
Pooler Imaging Center

CT & IV Contrast History and Screening Form

Patient Name: ______________________ **DOB:** _____________ **Age:** _______

Allergies: _____________________________

Have you ever had a reaction to iodine or x-ray contrast? ☐ Yes ☐ No

If yes, please explain: ____

Surgeries: ____

Pregnant: ☐ Yes ☐ No

Any Personal History Of:

Asthma ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

What kind of medication do you take for diabetes? _____________________

Kidney Disease ☐ Yes ☐ No

Dialysis? What days? ____

Multiple Myeloma ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

If yes, what form, and have you had any treatment?

____

Symptoms: ____

For Technologist Use Only:

ISTAT LABS: Creatine: ________________ GFR:_____________ Date:________

Oral Start Time: _____________ Omnipague_____/_______cc

Lot Number________ GA IV in the _________

Contrast Reaction: ☐ Yes ☐ No