# CAHABA VALLEY IMAGING

## CT TECH SHEET

Patient:_____ Age:_____

YES OR NO:

_____ 1. Do you have a pacemaker, defibrillator, or implanted mechanical or electrical device?

_____ 2. Have you had cancer? What type_____

_____ 3. Are you diabetic?
If so, are you on glucophage (Metformin)?_____

_____ 4. Do you have hypertension (high blood pressure)?

_____ 5. Do you have a history of cardiovascular disease?
_____Heart Surgery _____Heart Medication

_____ 6. Do you have a history of renal (kidney) disease?

_____ 7. Have you ever had a reaction to contrast (x-ray dye)?

_____ 8. Is there a possibility of pregnancy? LMP_____

_____ 9. Any allergies to any medications? _____

_____ 10. Is today's scan related to <u>any</u> injury; if so, when? _____

Current complaint:_____
Prior surgery:_____

_____ _____
Contrast administered Patient's signature

_____ _____
Technologist's signature Date