ROUND ROCK IMAGING
RADIOLOGY

Welcome to our Imaging Center

Cat Scan (CT) Screening for Patients

Name ____ Age _____ Height __________ Weight __________

Date of Birth ______________ Gender: M / F Area to be examined: ______________________________

Ordering Physician: _________________________ Primary Care Physician: ___________________________________

Do you have a scheduled follow up appointment to go over these results? Yes / No if so when: _____________________

Do you want the result to go to another provider? If Yes then, provide name and phone # ___________________________

Please describe in your own words your pain or the reason you are here today, please be as descriptive as possible:

____

____

____

Are you pregnant? ________ Yes ________ No _______ N/A Last menstrual period: ____________________

Have you had any other exams related to this problem? (MRI, CT, Ultrasound, X-ray)_____________________________
When? ___________________________________ Where? ____
Please notify the front desk if there are any outside films that need to be delivered to Our Facility for comparisons.

List any previous surgeries: ____

Any Personal History of:

___ Yes ___ No Asthma
___ Yes ___ No COPD
___ Yes ___ No Diabetes
___ Yes ___ No Kidney Disease
___ Yes ___ No Multiple Myeloma
___ Yes ___ No Prostate Problems
___ Yes ___ No Seizure Disorder
___ Yes ___ No Dizziness/HA's
___ Yes ___ No Heart Disease/CHF
___ Yes ___ No History of Stroke
___ Yes ___ No Liver Disease
___ Yes ___ No Bladder Disease
___ Yes ___ No Sickle Cell Anemia
___ Yes ___ No Hyper/Hypotension
___ Yes ___ No Cancer, What Type? ___________________________________

If Yes to any of the above please explain: ____
____

Contrast History

Are you currently taking Glucophage, Glucovance, or Metformin? ____
List any drug and or latex allergies: ____
Have you ever had an allergic reaction to X-Ray dye (IV Contrast) in the past? ____________________________
If so Please explain: ____

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask any questions in regards to the information on this form.
I am consenting to treatment at Round Rock Imaging LTD

Patient or Parent/Guardian Signature: ______________________________ Date: ____________

CT Tech Signature____ Date_____________

ROUND ROCK IMAGING
RADIOLOGY

Welcome to our Imaging Center

Technologist Portion

Contrast Type: ____ Volume: __________________________

Lot #: ______________________________ Exp. Date: ______________________ Location:_________________

# of Attempts: ____________ Was the power injector used? ___ Yes ___ No Rate of injection: ______________

Post contrast reaction ___ Yes ___ No

Physician covering the injection: ____

Technologist Comments: ____

____

____

____

____

CT Technologist signature: ____ Date: ______________