Print Reset Form

MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Last 4 numbers of SS#:_____
Referring Physician: _____ Height: _____ Weight: _____

Reason for Exam: _____
How long have you had this problem? _____ Are you seeing your physician in the next 24 hours? ☐ Yes ☐ No

Medical history (check all that apply) ☐ Diabetes ☐ High blood pressure ☐ Smoking ☐ Kidney disease/failure ☐ Asthma

☐ COPD ☐ Dialysis ☐ Multiple myeloma ☐ Adrenal Gland Tumor ☐ Heart Disease ☐ Lung Disease

Have you been treated for cancer? ☐ Never ☐ Currently ☐ Previously ☐ Treatment completed

Cancer type: _____ Approximate date of cancer diagnosis: _____

List any major surgeries: _____

Prior studies
Have you had previous related imaging studies done? ☐ Yes ☐ No What part(s) of your body? _____

Where did you get these exams done? _____ What year? _____

Type of exam: ☐ X-Ray ☐ CT ☐ MRI ☐ Ultrasound ☐ Nuclear Medicine ☐ PETCT

How many CT or Cardiac Nuclear Medicine studies have you had in the last 12 months? _____

Pregnancy Disclosure (*section required for all female patients between the ages of 10 and 55*)
Initial:

_____ **No, I am not** pregnant at the time of this x-ray examination / _____ **Yes, I am** pregnant at this time

_____ I realize that x-rays/radiation may be harmful to my unborn child; however, I wish to continue with today's exam.

Have you had tubal ligation or partial/full hysterectomy? ☐ Yes ☐ No Date of last menstrual period (LMP): _____

Iodine contrast history (*only for patients having contrast exams*)
Have you ever had previous imaging that required injection of contrast media/dye? ☐ Yes ☐ No
Have you ever had an allergic reaction to IV Contrast used in any imaging procedure (CT, MRI, X-Ray)? ..... ☐ Yes ☐ No
Are you taking Glucophage? Glucovance? (Metformin) ..... ☐ Yes ☐ No
Are you taking Avandament, Actoplusmet, Fortemet, Kombiglyze, Prandimet, Riomet, Glumetza, or Janumet? ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____

Baptist M&S Staff Full Signature: _____ **Date:** _____

---------- SECTION BELOW ONLY FOR TECHNOLOGIST AND BAPTIST M&S PERSONNEL ----------

Patient Fasting? ☐ Yes ☐ No Enteric Contrast: Rectal / Oral Type: _____ Contrast Type Injected: _____

Volume _____ ml. Lot#:_____ Exp. Date: _____ IV Access: Time: _____ Location: _____

Catheter Size/Type: _____ Number of Attempts: ____ IV Started By: _____ Injected By: _____

Allergy problems post contrast? ☐ Yes ☐ No Date Lab Drawn: _____ Creatinine within normal limits: ☐ Yes ☐ No ☐ NA

If no, Creatinine Level: _____ B.U.N. Level: _____ Notes:_____

_____

Baptist M&S Staff Full Signature: _____ **Date:** _____