

**MRI & IMAGING CENTER
CT INFORMATION FORM**

Name _____ Date of Birth _____ Sex ____ Weight _____

Requesting Physician _____ Family Physician _____

What problems or symptoms are you experiencing :BE VERY SPECIFIC: _____

Any recent injury or surgery in the affected area? _____

Do you have a history cancer, if so please specify? _____

Please list any previous testing, xrays,or ultrasounds for this condition and name of facility: _____

Additional pertinent medical history including surgeries:list dates and at name of
facility: _____

Do you have a history of kidney or liver disease? _____

Are you Diabetic: _____

Do you take diabetic medicine:Glucophage or Metformin Hydrochloride? Yes or No(circle one)

Do you have any Allergies to food, medications or Latex?:Yes or No(circle one)
If yes , Specify & list type of reaction _____

Do you have asthma? _____

Females Only: Possibility of Pregnancy: Yes or No (circle one)

I have answered these questions to the best of my knowledge and understand the information presented
to me.

Patient Signature _____ Date _____

Technologist Signature _____ Date _____

Technologist: Did patient receive CD or FILMS?