Big Sky Diagnostic Imaging of Billings

Computed Tomography (CT) Procedure Screening Form

PATIENT INFORMATION

NAME _____ DOB _____ HEIGHT _____ WEIGHT_____

BODY PART TO BE EXAMINED_____ REFERRING PHYSICIAN_____

REASON FOR CT / CTA (SYMPTOMS AND/OR CONDITION)_____

SAFETY SCREENING

1. Have you ever had a prior surgery or operation of any kind? YES ❑ NO ❑
   If "Yes," please give a brief description of the type and date of the surgery:_____
2. Have you had a prior MRI, CT, Ultrasound, X-ray, etc.? YES ❑ NO ❑
   If "Yes," please list type, date, and the facility where it was performed:_____
3. Have you ever experienced any problems related to a previous CT examination? YES ❑ NO ❑
   If "Yes," please describe:_____
4. Do you have any conditions and/or disease(s) of your heart? YES ❑ NO ❑
   If "Yes," please list:_____
5. Are you currently taking any medication? YES ❑ NO ❑
   If "Yes," please list:_____
6. Do you have any known allergy to iodine, or have a history of asthma? YES ❑ NO ❑
   If "Yes," please list:_____
7. Have you ever had a reaction to a contrast medium ("dye") used during any MRI, CT, or X-ray examination? YES ❑ NO ❑
8. Do you have diabetes or any disease(s) of your kidneys or blood? YES ❑ NO ❑
   If "Yes," please describe:_____

Female Patients:

9. Are you pregnant or experiencing a late menstrual period? YES ❑ NO ❑
10. Are you currently breast feeding? YES ❑ NO ❑

I attest that all the information provided is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to address any questions or concerns I have regarding the information on this form.

Signature of Person Completing Form:_____ Date:_____