VISALIA IMAGING & OPEN MRI **CT PATIENT INFORMATION FORM**

PLEASE FILL OUT THE FORM BELOW. THIS WILL ENABLE US TO DO A SAFE AND ACCURATE EXAMINATION.

DESCRIBE THE MEDICAL PROBLEM(S) AND SYMPTOMS WHICH BROUGHT YOU HERE TODAY:

____

____

WHAT IS YOUR HEIGHT:________ WEIGHT:______ ARE YOU PREGNANT?___________

HAVE YOU HAD ANY PREVIOUS SURGERIES? YES ____________ NO ____________
IF SO, PLEASE LIST:

____

ARE YOU ALLERGIC TO IODINE? YES ____________ NO ____________
WHAT TYPE OF REACTION DID YOU HAVE:

____

ARE YOU A DIABETIC? YES ____________ NO ____________
IF SO, ARE YOU TAKING GLUCOPHAGE, GLUCOVANCE OR METFORMIN? YES ______ NO _______

DO YOU HAVE:
ASTHMA OR EMPHYSEMA? YES ____________ NO ____________
HEART DISEASE? YES ____________ NO ____________
DO YOU HAVE ANY KIDNEY PROBLEMS? YES ____________ NO ____________
IF SO, PLEASE EXPLAIN:

____

PLEASE LIST ANY PREVIOUS STUDIES IN THE <u>AREA OF CONCERN:</u> CT OR OTHER IMAGING STUDIES SUCH AS MRI, XRAY, OR ULTRASOUND, ALONG WITH THE APPROXIMATE DATES AND WHERE THEY WERE PERFORMED.

____

BY SIGNING BELOW, YOU INDICATE THAT YOU HAVE READ THE ABOVE INFORMATION AND ANSWERED ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. FURTHER YOU AGREE TO BE IMAGED USING COMPUTED TOMOGRAPHY.

______________________________ ____________ ______________________________
SIGNATURE **DATE** **WITNESS**

MEDICAL OFFICE USE ONLY

ORAL CONTRAST:
READI CAT 900ml YES or NO
VOLUMEN 1350ml YES or NO

IV CONTRAST: ISOVUE 300/75 ml ________________
ISOVUE 370/100 ml ________________
ISOVUE 370/150 ml ________________
VISIPAQUE 320/100ml_______________

TECHNOLOGIST NOTES: ____

____