CT Screening

Patient Name:_____

Today's Date: _____ **Age**: _____ **Weight**: _____ **Height**: _____ **Sex**: ☐ **M** ☐ **F**

	Yes	No	
	☐	☐	If female: is there any possibility you could be pregnant?
	☐	☐	Are you currently breastfeeding?
	☐	☐	Have you had a previous reaction to iodinated contrast media (i.e. CT contrast dye or X-ray dye)? If yes, describe reaction: _____
	☐	☐	If you had a prior reaction to iodinated contrast media, have you been pre-medicated with a corticosteroid (such as Prednisone or Solu-Medrol)? _____
	☐	☐	Do you have any allergies to food or medication? If yes, please list: _____
	☐	☐	Do you have asthma?
	☐	☐	If yes, is your asthma currently affecting you?
Δ	☐	☐	Do you take Glucophage (Metformin)?
Δ	☐	☐	Do you have kidney disease or kidney failure or kidney transplant?
Δ	☐	☐	Do you have a history of kidney cancer or mass?
Δ	☐	☐	Do you have a family history of kidney failure?
Δ	☐	☐	Have you previously had kidney surgery?
*	☐	☐	Have you had a recent illness or infection in the past week? Type: _____
*	☐	☐	Have you been feeling sick with nausea, vomiting or diarrhea?

_____ _____ _____

Signature of Patient or Legal Guardian **Printed Name** **Date**

_____

If signed by person other than patient, provide printed name, relationship to patient, description of authority

THIS SECTION IS FOR STAFF USE ONLY

* Serum creatinine within 24 hours Δ **Serum creatinine within 2 weeks if "Yes" to answer**

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

CT SCREENING

U2359

UH2359 REV OCT 19