

**CT/IVP  
VALLEY IMAGING CENTER**

Patient ID # \_\_\_\_\_

**Exam:** \_\_\_\_\_

**Please Print**

Date: \_\_\_\_\_ Ordering Physician: \_\_\_\_\_

Office Phone #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female

DOB \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Phone# \_\_\_\_\_

What are you symptoms/complaints? \_\_\_\_\_

How long have you had the symptoms? \_\_\_\_\_

Do you have ANY food or drugs allergies? YES NO

If so, please list, including reactions: \_\_\_\_\_

Have you had any surgeries? YES NO If yes, what type and when? \_\_\_\_\_

Have you had any blood work done in the last 48 hours? YES NO

If yes, where? \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

Have you ever had an MRI or CT before? YES NO

If yes, when and where? \_\_\_\_\_

Have you had any xrays done recently? YES NO

If yes, when and where? \_\_\_\_\_

Do you have or have you had any of the following?

Heart Failure (CHF) Bleeding Disorder

Renal (Kidney) Failure TIA/Stroke

Diabetes Asthma/COPD

Cancer \_\_\_\_\_ Stints: Where \_\_\_\_\_

Liver Problems Smoke: How Much \_\_\_\_\_ How Long \_\_\_\_\_

Tubal Ligation Hysterectomy? Total/Partial

Date of last menstrual period? \_\_\_\_\_

If DIABETIC, do you take any of the following?

Glucophage	YES	NO	MetaGlip	YES	NO
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Glucovance	YES	NO	Metformin	YES	NO
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Avandamet	YES	NO	Fortamet	YES	NO
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Riomet	YES	NO			
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Patient Signature: \_\_\_\_\_

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For Office Use Only

Impression: \_\_\_\_\_

BUN \_\_\_\_\_ CREATININE \_\_\_\_\_ GFR \_\_\_\_\_

TYPE OF CONTRAST \_\_\_\_\_ AMOUNT \_\_\_\_\_ ROUTE \_\_\_\_\_

Technologist: \_\_\_\_\_