McLaren

THUMB REGION

RADIOLOGY/CT PATIENT HEALTH ASSESSMENT

Diagnostic Imaging Dept. 989-269-8933 ext 4560

Name:_____ Age:_____ Sex: M F

Any possibility of pregnancy? Yes No
Have you ever had a contrast reaction? Yes No
If yes, please describe:_____
_____

Please list any surgeries that are related to the exam: _____
_____
_____

PERSONAL MEDICAL HISTORY:

Multiple Myeloma	Yes	No	Diabetes	Yes	No	Insulin / Pills
Kidney Disease	Yes	No	Heart Disease	Yes	No	
Lung Disease	Yes	No	Cancer History	Yes	No	
Pheocromocytoma	Yes	No	Sickle Cell	Yes	No	

What types of Cancer: _____
_____
_____

TECHNOLOGIST USE ONLY

PRIOR RELEVANT EXAM:_____DATE: _____
LOCATION:_____

Creatinine/GFR: _____ Date:_____

IV Contrast: Isovue 350 Amount:_____

IV Site:	Right Hand	Left Forearm	Antecubital	Other:_____
IV Gauge:	22g	20g	18g	22g Diffusics

Tech Comments/ Pertinent Patient History: _____
_____
_____
_____

Technologist:_____

Time:_____ Date:_____