Gulf Coast MRI & Diagnostic
www.gulfcoastmri.com

CAT SCAN HISTORY WORKSHEET

Date of Exam ______/______/______ Time of Exam __________ am/pm

Patient Name ________________________________ D.O.B ______/______/______

Technologist ______________ Referring Physician ____________ Oral Contrast __________

Amount Given: ______________ Type and Quantity of IV contrast: _____________________

Injection Site: ___________ Lot # ____________________ Exp. Date ____/____/______

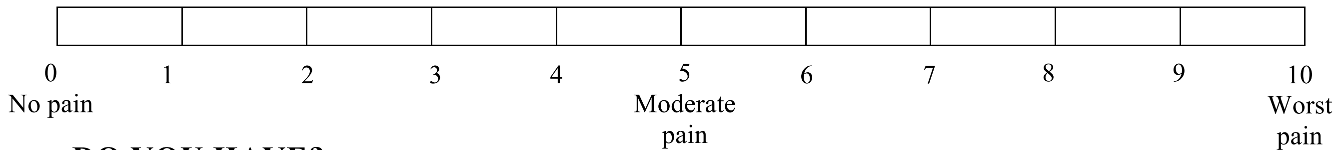
Time of Injection ________ am/pm Creatinine: ________________ eGFR: _____________

Physician Diagnosis ____

Pain? **Y** **N** If yes, where? ____

When did the pain occur? __________________ How did the pain occur? ________________

Rate pain from 0 to 10 with 0 indicating no pain and 10 representing the worst possible pain



DO YOU HAVE?

Asthma	____YES ___NO	Arrhythmia	____YES ___NO	Constipation	____YES ___NO
Hay fever	____YES ___NO	Aortic Stenosis	____YES ___NO	Headaches	____YES ___NO
Lung disease	____YES ___NO	CABG	____YES ___NO	Diarrhea	____YES ___NO
Emphysema	____YES ___NO	Heart attack	____YES ___NO	Dizziness	____YES ___NO
Ulcer	____YES ___NO	Angina	____YES ___NO	Blurred vision	____YES ___NO
Chest pain	____YES ___NO	Syncope	____YES ___NO	Pulmonary Hyper	____YES ___NO
Cough	____YES ___NO	Hematuria	____YES ___NO	Nausea	____YES ___NO
COPD	____YES ___NO	Blood in stool	____YES ___NO	Vomiting	____YES ___NO
Hives	____YES ___NO	Hernia	____YES ___NO	Numbness/ tingling	____YES ___NO
Heart Failure	____YES ___NO	Weight loss	____YES ___NO	Shortness of Breath	____YES ___NO

Limitations/Notes____

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Previous Studies: Yes No **STAT Studies:** Yes No