LOMPOC VALLEY MEDICAL CENTER
Lompoc Healthcare District

CT SCREENING FORM

Patient Name:_____ DOB:_____
MR#:_____ Date:_____

Have you had iodine-containing radiographic contrast previously? ☐ Yes ☐ No

Did you have a reaction to the contrast? ☐ Yes ☐ No

If yes, what year? _____

Where was the scan done? _____

Please describe what happened when you got the injection:

Do you have allergies? ☐ Yes ☐ No

If yes, please list: _____

Do you have kidney disease? ☐ Yes ☐ No

If yes, are you on dialysis? ☐ Yes ☐ No

What days? ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

Do you have diabetes? ☐ Yes ☐ No

Do you have cancer, or have you ever had cancer? ☐ Yes ☐ No

If yes, what kind, when, and treatments:_____

Could you be pregnant? ☐ Yes ☐ No

Date of your last menstrual cycle:_____

Have you had any surgeries? ☐ Yes ☐ No

If yes, what, where, and when: _____

Do you have a Port-A-Cath? ☐ Yes ☐ No

Do you have difficult veins? ☐ Yes ☐ No

Do you prefer to use your Port or have an IV started? ☐ Yes ☐ No

Do you have high blood pressure that requires medication? ☐ Yes ☐ No

Have you had prior CT scans of this area? ☐ Yes ☐ No

If yes, where and when:_____

Height: _____ Weight:_____ BMI:_____