Advanced Shore Imaging Associates
2605 Shore Road
Suites 101 & 201
Northfield NJ 08225

CT SCREENING FORM

Patient Name_____ **Date of Birth**_____

1. Are you having any symptoms? If so please describe:_____
2. Any prior studies pertaining to the reason you are having this test?_____
3. Height _____ Weight _____

4. **MEDICAL HISTORY** (Please circle all that apply)

Cancer_____	Asthma	Sickle Cell
Chemotherapy	Hypertension	Myasthenia Gravis
Radiation Therapy	Thyroid Disease	Multiple Myeloma
COPD/Emphysema	Diabetes	Polycythemia Vera
History of Smoking	Stroke	Kidney/Renal Disease

5. Please give date and type of **any** surgery: _____
   _____
6. Please list any allergies to food or drugs:
   _____
7. Please list any medications you are taking (i.e. Metformin, Glucovance, etc.) _____
   _____
8. Any possibility of pregnancy? **Yes** **No** **Don't know** Are you breast feeding? **Yes** **No**

First date of last menstrual period? _____

Signing below indicates that you have read and understand this form and have completed it to the best of your ability

Patient or Legal Representative Signature_____

TECH NOTES:

IV Contrast: OMNIPAQUE 350 VISIPAQUE 320 270

PO Contrast: OMNI 350 VOLUMEN OMNI 240 READICAT

20- ANGIO 22- ANGIO 23- BUTTERFLY

ANTICUBE ARM HAND R L _____ML _____LOT _____EXP

Creatinine_____ GFR_____ Date_____

Tech Signature _____Date_____