NORTHERN LIGHTS
IMAGING

CT PATIENT SCREENING

HEIGHT: _____ WEIGHT: _____

1. Do you have a history of Diabetes? YES NO
2. Do you take any Diabetes medications? YES NO

   If yes, what type (circle)

Metformin	Glumetza	Glucovance
Glucophage	Fortamet	Actoplusmet
Glucophage XR	Riomet	Avandamet

3. Do you have a history of Asthma? YES NO
4. Do you have a history of Cancer? YES NO

   If yes, what type? _____

   What year was it diagnosed? _____

   What type of treatment have you had? _____

5. Do you have a history of Kidney Disease? YES NO
6. Do you have a history of Multiple Myeloma? YES NO
7. Do you have a history of Pheochromocytome? YES NO
8. Do you have a history or Polycythemia? YES NO
9. List any previous surgeries:

   _____

   _____
10. List any medications you are allergic to: _____
11. Do you have an allergy to Iodine?: YES NO
12. List dates and locations of prior CT imaging related to today's exam:

    _____

    _____
13. Why are you have this CT exam today? (Please be specific and list all of your symptoms)

    _____

    _____

Patient/Guardian Signature: _____ Date:_____

**********Official Use Only**********

BUN: _____ Creatinine: _____ Radiologist Signature: _____

TECH INITIALS: _____