Tower Radiology Centers
CONTRAST EVALUATION FORM (CT/MRI/Fluoro)

DATE: _____ EXAM: _____

PATIENT NAME: _____ PID: _____ AGE: _____

PHYSICIAN: _____ PHONE: _____

SYMPTOMS/REASON FOR EXAM: _____

MEDICINE ALLERGIES: _____

FOOD ALLERGIES: _____

WHAT HAPPENS WHEN YOU HAVE A REACTION? _____

MEDICAL HISTORY

Pregnant? **YES** **NO** If so, how far along? _____

Diabetes? **YES** **NO** If so, what medication are you taking? _____

Hypertension? **YES** **NO**

Kidney Disease? **YES** **NO**

Sickle Cell? **YES** **NO**

Multiple Myeloma? **YES** **NO**

Previous Contrast Injection? **YES** **NO**

Reaction from contrast? **YES** **NO** If so, what happened? _____

Asthma? **SEVERE** **MILD** **NO** If so, do you regularly use an inhaler? **YES** **NO**

Smoker? **YES** **NO**

Please list previous surgeries _____

History of Cancer? **YES** **NO** Type and treatment? _____ **Chemo** **Radiation**

Previous CT, MRI or X-ray? **YES** **NO** If so, when and where? _____

Recent lab work? **YES** **NO** If so, when and where? _____

PATIENT SIGNATURE: _____ **DATE:** _____

TECHNOLOGIST TO COMPLETE

BUN: _____ CREATININE: _____ GFR: _____ STAGE: _____

Technologist Comments: _____

Technologist Signature _____ Date: _____

Revised 07/02/2019