Medical Report

Full Name: _____ Date of Birth: _____

Please answer 'yes' or 'no' to the following questions. If in doubt consult your doctor.

If answering 'yes' on any point give details below. Use a separate sheet if necessary.

1. Do you have recurring / ongoing problems in the following areas?

Headaches	_____	Epilepsy / Fits	_____
Earaches	_____	Diabetes	_____
Sore Throats	_____	High Blood Pressure	_____
Sinus Trouble	_____	Fainting Episodes / Blackouts	_____
Toothache	_____	Back, Neck or Joint Problem	_____
Eye Strain	_____	Stomach Upsets	_____
Dyslexia	_____	Bladder Trouble	_____
Asthma	_____	Tenosynovitis / R.S.I.	_____
Hay Fever	_____	Depression/Nervous Illness/ Mental Disorder	_____
Skin Condition	_____	M.E. (Myalgic Encephalomyelitis) / Chronic Fatigue Syndrome	_____
Allergy	_____	Anorexia/Bulimia	_____

Tuba City Regional Health Care Corporation
Radiology Department

Consent Form for Contrast Examination
Computed Tomography (CT)

Your physician Dr. ______________ has requested an x-ray examination, which will involve the injection of contrast material into your body through a blood vessel. The contrast flows through a small needle in your hand or arm. [illegible] On very rare occasions, death may occur.

Medications and personnel are here to treat any of these events. Your physician feels that the information from the examination outweighs the small risk of the study. [illegible] Please answer all of the following questions:

1. Have you had previous contrast study, such as kidney or blood vessel study? Yes No
   If yes, what type of study?
   Did you have any problems or difficulty with the injection? Yes No
2. Any history of allergy to iodine, foods, drugs or medications? Yes No
   If yes, to what substances are you allergic?
3. Do you have any history of: (please circle if YES)
   Hypertension Asthma Diabetes Seizures Tumors
   Kidney Disease Aneurysm Myeloma Heart Disease
4. Do you take Glucophage/Metformin? Yes No [illegible]
   BUN Creatinine Date

FEMALES: Is there a possibility that you may be pregnant? Yes No
When was your last menstrual period? Date

Technologist Use Only
Contrast Load/Volume Time of Injection

Injection Site/Needle Size Technologist Signature Date/Time

The examination has been explained to me including the benefits and alternative examinations. All questions have been answered to my satisfaction. I understand the above and consent to and agree with having this examination.

PATIENT Signature **Date & Time** **Witness** **Date & Time**

TRANSLATOR (if needed) **Date & Time** **LEGAL GUARDIAN Signature** **Date & Time**
[illegible]

I have counseled this patient as to the procedure(s), attendant risks and expected results.

PHYSICIAN Signature **Date & Time** **Name of Medical Facility**

[illegible]