Cardiac CT
Screening Form

Diagnostic Imaging Services

3181 S.W. Sam Jackson Park Road, Portland, Oregon 97239
Phone: 503-418-0990 Fax: 503-494-5020

Patient Name: _____ Height: _____ Weight: _____

1. Please list all medications that you are currently taking?
   _____
   _____

2. Are you allergic to any medications?..... ☐ Yes ☐ No
   Please list them along with the reaction that occurred when taken. _____
   _____

3. What is the reason you are having this scan?
   _____

Prior Testing: Please indicate if you have had any of the following procedures. If yes, please indicate when (the most recent if multiple times) and where (name of the hospital or clinic).

		When?	Where?/How Many?
☐	By-Pass Surgery		
☐	Stents		

Other Medical History: Please indicate if you have or have had any of the following:

	YES	NO	UNSURE
Valvular heart disease (or heart valve disease such as regurgitation or leaky valve or stenotic valve)?	☐	☐	☐
Asthma or emphysema?	☐	☐	☐
Do you use an inhaler?	☐	☐ How often____	
Do you use home Oxygen?	☐	☐ Liters _____	
Have you been hospitalized for asthma or emphysema?	☐	☐	☐
Have you been intubated or on a ventilator?	☐	☐	☐
Do you take any medications for erectile dysfunction?	☐	☐	☐
Kidney disease?	☐	☐	☐
Are you allergic to I.V. contrast or I.V. dye or X-Ray dye or Iodine?	☐	☐	☐
Is there any chance you could be pregnant?	☐	☐	☐
Are breast feeding?	☐	☐	☐

Thank you for choosing OHSU for your diagnostic imaging needs.

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Scan to OP-1980