Oregon Health & Science University
Diagnostic Imaging Services

Cardiac CT Screening Form

Name:
MRN:
Account No:
Birth Date:

Place patient label here

Print Name: _____ Height: _____ Weight: _____

Thank you for choosing OHSU for your diagnostic imaging needs

Why are you having a Cardiac CT scan today?

_____

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 facility (name of the hospital or clinic).

		Date	Facility
☐	By-Pass Surgery		
☐	Coronary, Aortic or other **Cardiac Stent**		
☐	Mechanical Heart Valve Replacement		

Other Medical History:

Do you have a history of aortic stenosis?	☐ Yes ☐ No
Do you have a pacemaker or ICD (implantable cardioverter-defibrillator)?	☐ Yes ☐ No
Do you have ☐ asthma ☐ emphysema or ☐ COPD (chronic obstructive pulmonary disease)	☐ Yes ☐ No
Do you use an inhaler on a daily basis for asthma, emphysema, or COPD? How often do you use your inhaler? _____ Last used: _____	☐ Yes ☐ No
Have you ever been hospitalized because of asthma, emphysema, or COPD?	☐ Yes ☐ No
Have you ever been intubated or on a ventilator because of asthma, emphysema, or COPD?	☐ Yes ☐ No
Do you use home oxygen? How many liters? _____	☐ Yes ☐ No
Do you take the medication Cialis (Tadalafil), Viagra (Sildenafil), or Levitra (Verdenafil)? Time/Date last taken: _____	☐ Yes ☐ No

The above information is correct to the best of my knowledge. I have read and understand the contents of this form. I had the opportunity to ask questions about the information on this form and the imaging procedure I am about to have.

Date: _____ Signature of person completing form: _____

Relationship to Patient: ☐ Self ☐ Relative ☐ RN ☐ Physician ☐ CT Tech ☐ Other: _____

Name of Imaging Staff reviewing form: _____