DERRY IMAGING
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C.T. Contrast Questionnaire Form

Patient Name_____

Height_____ Weight_____ DOB_____ AGE_____ Date of Exam_____

Please explain your symptoms or the reason you are having this exam:

_____

Do you have a history of:

Renal (kidney) disease, stones or infection?
Family History of renal disease?
Blood in urine?
Diabetes?
Heart disease?
Hypertension?
Multiple Myeloma?
Are you a dialysis patient?
Bladder surgery?
Heart surgery?
Liver surgery?
Spine surgery?
Arthroscopy?

Gallbladder removed?
Appendix removed?
Uterus removed?
Ovary(ies) removed?
Spleen removed?
Hernia repair?
Colon or intestine surgery?
Prostate surgery?
Kidney surgery?
Lung surgery?
Brain surgery?
Joint surgery?
Pancreas surgery?

Any chance of pregnancy?_____

Do you have a history of cancer? If you answered yes, what type of cancer, when was it found and what type of treatment have you had?_____

_____

Have you had I.V. contrast (x-ray dye) in the past?
When:_____ Where:_____ Any Reactions:_____

Have you ever had an: (please circle)

IVP Arthrogram Angiogram CAT SCAN with contrast
Venogram Cardiac Catheterization T-Tube Cholangiogram
Fistulagram

Please list all allergies_____

Please list all medications that you are taking:_____

_____

Glucophage, Avandamet and Metaformin patients: Stops these drugs for 48 hours after this test

Patient Signature_____Date_____

To be completed by the Technologist

Contrast selected_____ Amount given_____Lot #_____
Expiration date_____ Injected by_____Radiologist on site_____
Glucophage letter given:_____ Post contrast sheet given:_____
Premeds taken_____ Date:_____