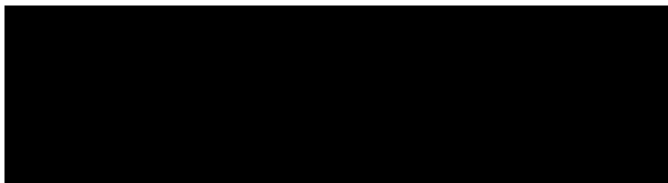

C.T. Contrast Questionnaire Form

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:___________