Beth Israel Lahey Health

Beth Israel Deaconess Needham

Contrast Screening Questionnaire

Name _____ Date _____

MR# _____ DOB:____/____/____ Height _____ Weight _____

1. What symptoms / issues have you been having that has led to the test being ordered? _____

_____

2.	Did you bring outside X-Ray films for comparison?	No ___	Yes ___
3.	Have you had a CT Scan before?	No ___	Yes ___
4.	Do you have a history of Cancer? If yes, type:_____	No ___	Yes ___
5.	Are you undergoing Chemotherapy at this time?	No ___	Yes ___
6.	Have your received an injection of contrast for any scan in the past? *Example: IVP,CAT Scan, Angiography*	No___	Yes ___
7.	**Do you have allergies to IV Contrast or Iodine?**	**No ___**	**Yes ___**
8.	Do you have a Hickman or Porta-Cath IV device placed under the skin for access?	No ___	Yes___
9.	Are you allergic to any foods or medications? If YES, Please list:	No ___	Yes ___

_____

10.	Do you have diabetes?	No___	Yes ___
11.	Do you take; *Metformin, Metformin XR, Glucophage, Glucophage XR, Glucovance, Fortamet, Avandamet, Pandimet, Actoes Plus Met, Actos Plus Met, Glumetza, Rioment, Metaglip or Janumet, or any other oral diabetes medication?*	No ___	Yes ___

12. Please list all your medications (Use the back of this form if needed) _____

_____

13.	Are you on dialysis? If YES, please indicate how often _____	No___	Yes___

14. Please check the box if you have any of the following medical conditions:

□ Asthma	□ Sickle Cell Disease	□ Kidney Disease
□ Hay-Fever	□ Pheochromocytosis	□ Thyroid Disease
□ Hypertension (high blood pressure)	□ Multiple Myeloma	□ Heart Disease

15. **Females:** Are you, or could you be, pregnant? No ___ Yes___
16. If you are still menstruating, when was your last period? _____
17. Are you taking hormone replacement? No ___ Yes ___

Patient Signature _____

_____Department Use Only_____

IV Site: _____ **Gauge:**_____ **Technologist/IV tech/RN:** _____

Contrast Type: _____ **Amount to be injected:** _____ **Oral Contrast type:**_____

BUN: _____ **Creatinine:**_____ **Date:**_____

MD Signature: _____ **Date:**_____ **Time**_____

Revised May 2012