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 you 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? No ___ Yes ___
   If YES, Please list:
   ____________________________________________________________________________________

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? No___ Yes___
   If YES, please indicate how often __________________________

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_________________________________________________

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