CT Exam Questionnaire

NAME: _____ Date: _____ MRN: _____

Date of Birth: _____ Required: Weight:_____ Height:_____

Do you have any of the following conditions:

1.	Diabetes	❍ YES	❍ NO
2.	Renal insufficiency	❍ YES	❍ NO
3.	Currently on dialysis	❍ YES	❍ NO
4.	List all diabetic medicines	❍ YES	❍ NO
5.	_____		
6.	Pregnant/breast feeding	❍ YES	❍ NO
7.	Multiple myeloma	❍ YES	❍ NO
8.	Hyperthyroidism	❍ YES	❍ NO
9.	Thyroid Cancer	❍ YES	❍ NO
10.	Pacemaker	❍ YES	❍ NO
11.	Removable dentures/partials	❍ YES	❍ NO

Have you ever had a reaction to CT iodine contrast? Check all that apply:

1. Rash/Hives 2. Nausea/vomiting 3. Swelling; eyes, face 4. Difficulty breathing
5. Other_____

What are your symptoms regarding this exam today? _____
_____
_____

List all prior surgeries: _____
_____
_____

Have you had any other exams pertaining to this procedure? (Prior CT, Ultrasound, MRI, X-ray) and at which facility?
_____
_____

Are there any medical conditions or concerns that we should be aware of?
_____
_____

As part of your examination, the radiologist may deem it advisable to give you an injection of non-ionic iodine contrast. However, our radiologists reserve the right to deny contrast if not deemed necessary according to the ACR guidelines due to the potential impact contrast may have on the kidneys. Some reactions such as nausea, vomiting, change in blood pressure, skin rash, or other more severe reactions may occur but are uncommon

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature _____Date signed _____