RadiologicalGroup

CT

CT INTRAVENOUS CONTRAST QUESTIONNAIRE
Department of Radiology

Name:_____

DOB: _____

Yes	No	
		Have you had a similar CT scan before? Where?
		Have you ever had contrast (dye) like this before?
		Any reaction to contrast? If yes, describe:
		Are you allergic to any medications? **If Yes, Please List.**
		Have you had any solid food in the past 4 hours?
		Do YOU have a history of Cancer? What TYPE?
		Are you currently or ever had chemo/radiation? ARE YOU CURRENTLY TAKING INTERLUKIN II?
		Any history of Surgery in the area that we are scanning? What TYPE?

Yes*	No	**BOX 2**
		Are you currently taking Hydroxyurea?
		Are you 65 years of age or older?
		Do you have High Blood Pressure?
		Do you have Diabetes? Do you take any medications listed below: Please Circle:_____ **Avandamet,(Rosiglitazone/metformin),Metformin, Glucophage andXR, Fortamet, Glumetza, Riomet, Glucovance, (Glyburide/metformin), Metaglip, (Glipizide/metformin), Actosplus met, (Pioglitazone/metformin), Janumet, (Sitagliptin/metformin), Jentadueto, (linagliptin/metformin), Kombiglyze XR, (saxagliptin/metformin), PrandiMet, (Repaglinide/metformin**
		Have you ever had: Congestive Heart Failure/heart attack/atrial fibrillation/Angina/Bypass Surgery?
		Do you have any kidney disease/prior kidney tumor or transplant/ history of kidney surgery?
		Have you ever been diagnosed with multiple myeloma?
		Have you ever been diagnosed with Collagen vascular disease(scleroderma, systemic lupus)?
		Do you take ***HIGH*** Doses daily of Ibuprofen (Advil, Motrin), Naproxen (Aleve), Diclofenac, or Celebrex?

IF ANY "YES" ANSWERS IN **BOX 2**: CREATININE RESULT MUST BE OBTAINED:

[redacted]

FEMALES ONLY If "YES" is answered to ANY of the below, NO Pregnancy Test is Required

Yes	No*		
		Are you 55 years of age or older?	
		Have you had any of the listed surgeries?	**PLEASE CIRCLE: Hysterectomy / Tubal Ligation**

50 -55 years of age

		Has it been MORE than I year since your last normal menstrual period?

54 years of age and younger

		Has it been less than 10 days since the first day of your normal period? Date :_____

Patient Signature :_____Date:_____