Weill Cornell Imaging
at NewYork-Presbyterian

Date: ____ / ____ /_____ Name: _____

Address: _____

Phone Numbers: Home ( ) _____ Work ( ) _____

Age: _____ Height: _____ Weight: _____ Sex: M ☐ F ☐

Do you have an allergy to latex? ☐ **Yes** ☐ **No**

Do you have an allergy to iodine? ☐ **Yes** ☐ **No**

Have you had a previous reaction to X-ray dye? ☐ **Yes** ☐ **No**

Do you have any allergies to medicines? ☐ **Yes** ☐ **No**

If yes, please list the medications: _____

Do you have any of the following:

Known Significant Atherosclerotic Disease ☐ **Yes** ☐ **No**

Asthma ☐ **Yes** ☐ **No**

Pheochromocytoma ☐ **Yes** ☐ **No**

Kidney Disease ☐ **Yes** ☐ **No**

Last Dialysis ____/____/20____ ☐ **Yes** ☐ **No**

Hay Fever ☐ **Yes** ☐ **No**

Multiple Myeloma ☐ **Yes** ☐ **No**

Collagen Vascular Disease ☐ **Yes** ☐ **No**

Sickle Cell Disease ☐ **Yes** ☐ **No**

Receiving chemotherapy in the last two months ☐ **Yes** ☐ **No**

Diabetes with known/suspected kidney dysfunction ☐ **Yes** ☐ **No**

Are you taking insulin? ☐ **Yes** ☐ **No**

Oral Diabetic Medication Glucophage? ☐ **Yes** ☐ **No**

Please list medications taken regularly: _____

Last Menstrual Cycle: _____ **Are You Pregnant?** ☐ **Yes** ☐ **No** **Breastfeeding:** ☐ **Yes** ☐ **No**

Have you had a previous imaging scan at Weill Cornell Medical Imaging at NewYork-Presbyterian? ☐ **Yes** ☐ **No**

If so, when? _____

For what medical problems are you having this study? _____

How long have you had this problem? _____ Which side? ☐ Left ☐ Right

Have you had any surgery on the area to be examined? ☐ **Yes** ☐ **No**

List surgical procedures and dates: _____

Please turn page over…

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X-RAY: CONTRAST QUESTIONNAIRE

Your imaging procedure requires the administration of an X-ray dye/contrast (these are two commonly used names for the same thing) which helps the physician interpret your examination.

Have you ever had an injection of X-ray dye/contrast? ☐ **Yes** ☐ **No**

Have you ever had X-ray dye/contrast by mouth, rectum, or other body cavity? ☐ **Yes** ☐ **No**

Have you ever had, as a result of x-ray dye/contrast, any of the following:

Hives: ☐ **Yes** ☐ **No**

Shortness of breath: ☐ **Yes** ☐ **No**

Fainting of collapse: ☐ **Yes** ☐ **No**

X-ray dye/contrast is administered by either an injection through a small needle place into your vein or by mouth, rectum, or body cavity. During the administration of the X-ray dye/contrast you may experience a feeling of warmth, which is normal and expected.

Administration of X-ray dye/contrast is quite safe. However, there is a risk of a reaction. Uncommonly (1 out of 1,000), patients develop sneezing and hives. Very rarely (1 out of 70,000), death has occurred related to an adverse response to the X-ray dye/contrast.

If you have any questions, please speak to any staff member and they will contact a physician to answer your questions.

Questionnaire Completed By:

_____ _____ _____/_____/20_____
Print Name Signature Date

Questionnaire Reviewed By:

_____ _____ MD/RN/PA/TECH _____
Print Name Signature ID Code