CT Patient Questionnaire

Patient Name:	Date of Study:
Physician:	DOB: Age:

General Medical History

Reason(s) for today's exam: _____

_____

Do you have a history of cancer? If so, what type(s)? _____

_____

Do you have any history of surgery in the area being scanned? If so, what and when? _____

_____

Pregnancy

Is there any chance that you may be pregnant? If yes, inform the technologist now.	☐ YES ☐ NO
Date of last menstrual period: _____	
Are you nursing an infant?	☐ YES ☐ NO
If yes, stop nursing for 48 hours after contrast injection.	

Asthma/Allergy History

Do you have a history of asthma?	☐ YES ☐ NO
If yes, do you use an inhaler every day?	☐ YES ☐ NO
Have you ever been hospitalized for asthma?	☐ YES ☐ NO
Have you ever had a severe allergic reaction to anything requiring hospitalization, a breathing tube or epinephrine?	☐ YES ☐ NO

Contrast Allergy History

Is this the first time you have ever received x-ray contrast medication (x-ray dye) for an exam such as an IVP kidney exam, CT exam or angiogram?	☐ YES ☐ NO
Have you ever had an allergic reaction to x-ray contrast (x-ray dye)?	☐ YES ☐ NO
If yes, what reaction did you have? _____	

Steroid Premedication History

Have you ever taken or been instructed to take a steroid medication in preparation for an x-ray with contrast (x-ray dye)?	☐ **YES** ☐ **NO**
If yes, have you taken a steroid medication in preparation for today's exam?	☐ **YES** ☐ **NO**

Kidney Function History

Do you have diabetes treated with insulin or other medications?	☐ YES ☐ NO
Do you have a family history of kidney failure?	☐ YES ☐ NO
Do you have a history of "kidney disease" including tumor or transplant?	☐ YES ☐ NO
Do you have a history of paraproteinemia, e.g., multiple myeloma?	☐ YES ☐ NO
Do you have a history of collagen vascular disease, e.g., scleroderma or lupus?	☐ YES ☐ NO
Have you ever had prior kidney surgery?	☐ YES ☐ NO
Do you take Metformin containing drugs (these are drugs for diabetes, e.g., Glucophage or Glucovance)? If you are unsure, speak with the technologist .	☐ YES ☐ NO
Do you take non-steroidal anti-inflammatory (aspirin-like) drugs chronically or at high doses?	☐ YES ☐ NO
Do you regularly take medications that can cause kidney injury?	☐ YES ☐ NO
If you answered yes to any of the above, have you had a renal function test in the last 30 days (serum Creatinine blood tests)?	☐ YES ☐ NO

Cardiac History

Do you have angina or congestive heart failure?	☐ YES ☐ NO
Do you have severe aortic stenosis?	☐ YES ☐ NO
Do you have primary pulmonary hypertension?	☐ YES ☐ NO
Do you have severe cardiomyopathy?	☐ YES ☐ NO

Thyroid History

Do you have thyroid cancer?	☐ YES ☐ NO
If yes, do you expect to receive radioactive iodine in the next few weeks?	☐ YES ☐ NO

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient Name (Print)