



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
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Date of last menstrual period: _____		
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Are you nursing an infant?	YES	NO
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If yes, stop nursing for 48 hours after contrast injection.		
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Asthma/Allergy History

Do you have a history of asthma?	YES	NO
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If yes, do you use an inhaler every day?	YES	NO
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Have you ever been hospitalized for asthma?	YES	NO
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Have you ever had a severe allergic reaction to anything requiring hospitalization, a breathing tube or epinephrine?	YES	NO
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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
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Have you ever had an allergic reaction to x-ray contrast (x-ray dye)?	YES	NO
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If yes, what reaction did you have? _____		
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Steroid Premedication History

CT Patient Questionnaire
(continued)

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)