

RADIOLOGY/CT PRE-EXAM QUESTIONNAIRE FOR EXAMS WITH IV CONTRAST

Date: _____

Name: _____ DOB: _____/_____/_____

Procedure: CT Scan _____ IVP _____ Referring Physician: _____

If you are scheduled for a CT Scan of the abdomen and/or pelvis, have you drank the oral contrast?
YES _____ NO _____

Allergies: _____

Are you pregnant? **Yes** **No** **Date of last menstrual period** _____

Do you or have you had a history of any of the following? (Please circle response, if yes, briefly explain)

Kidney Disease Yes No _____

Lung Disease Yes No _____

Asthma Yes No _____

Heart Disease Yes No _____

High Blood Pressure Yes No _____

Diabetes Yes No _____

Excessive Bleeding Yes No _____

Cancer Yes No _____

 Radiation Therapy Yes No _____

 Chemo Therapy Yes No _____

Previous Surgery Yes No _____

Are you taking Glucophage or Glucovance? Yes No _____

Are you taking Blood Thinning Medication or Aspirin? Yes No _____

Any previous exams with X-Ray Contrast/Dye Injections? Yes No _____

Any previous reactions to X-ray Contrast/Dye Injections? Yes No _____

Type of Contrast _____ **Amount of Contrast** _____

Additional Medical History _____
