CT Contrast Injection Patient Questionnaire

Patient Name:_____

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

What is the reason this exam was ordered?_____

Yes	No	
☐	☐	1. Do you have any allergies to food or medicine? If Yes, please list:_____
☐	☐	2. If you had a previous reaction to a contrast injection in CT or MRI, what kind of reaction did you have? Describe reaction:_____
☐	☐	3. If you had a prior reaction to a contrast injection, have you been premedicated with a corticosteroid (such as prednisone or solumedrol)?
☐	☐	4. Are you allergic to latex?
☐	☐	5. **Do you have diabetes?**
☐	☐	6. If you have diabetes, are you on insulin?
☐	☐	7. **Do you take pills for your diabetes? Check all that apply** ☐ *Metformin* – containing medication ☐ other_____
☐	☐	8. Do you have asthma, COPD, emphysema or other respiratory problems?
☐	☐	9. If you have asthma, do you use an inhaler?
☐	☐	10. **Are you on hypertensive (high blood pressure) medication?**
☐	☐	11. Have you ever been told that you have had heart failure?
☐	☐	12. **Are you on any heart medication? Please list**_____
☐	☐	13. Do you have or have you ever had kidney problems in the past or present? Check all that apply: ☐ *kidney stones* ☐ *blood in urine* ☐ *renal cancer* ☐ *kidney transplant* ☐ *kidney removal* ☐ *renal failure* ☐ *chronic use of NSAIDs: advil /naprosyn/ibuprofen*
☐	☐	14. **If you have kidney problems--Have you been premedicated with Mucomyst ® (acetylcysteine)?**
☐	☐	15. **Are you on dialysis?**
☐	☐	16. Female: Is there any possibility you could be pregnant?
☐	☐	17. **Have you ever had a transplant? Are you being evaluated for a possible transplant? If yes, what kind?**_____
☐	☐	18. Have you had major surgery? If so, what type_____
☐	☐	19. **Do you have a history of vascular surgery for Arteriosclerosis?**
☐	☐	20. **Do you have Sickle Cell disease?**
☐	☐	21. **Do you have Myeloma?**
☐	☐	22. **Do you have active Gout?**
☐	☐	23. **Do you have Lupus?**
☐	☐	24. **Are you taking multiple antibiotics?**

PATIENT SIGNATURE	PRINT NAME	DATE

PT.NO

NAME

DOB

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University of Washington Physicians
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CONTRAST INJ PT QUESTIONNAIRE

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