New Jersey Institute of Radiology,PC, Carlstadt, NJ

COMPUTED TOMOGRAPHY QUESTIONNNAIRE

Name _____ Date of birth _____
Age: _____ Referring Physician: _____ Ht: _____ Wt:_____

Have you had anything to eat in the past 3 hours? ☐ YES ☐ NO
Have you had a barium study in the last few weeks? ☐ YES ☐ NO

PLEASE CHECK THE APPROPRIATE ANSWER

Allergies	**YES**	**NO**
Contrast/ X-ray dye	☐	☐
Latex	☐	☐
Food Allergy	☐	☐
If yes, to what? _____		
Hives due to allergy	☐	☐
Other _____	☐	☐

Personal Medical History	**YES**	**NO**
Asthma	☐	☐
Lung Disease	☐	☐
Heart Disease	☐	☐
Heart Failure	☐	☐
Arrythmia	☐	☐
Pacemaker	☐	☐
Other _____		
High Blood Pressure	☐	☐
Kidney Disease	☐	☐
Bowel / Bladder Disease	☐	☐
Hepatitis	☐	☐
Glaucoma	☐	☐
Diabetes	☐	☐
Sickle Cell Anemia	☐	☐
Stroke	☐	☐
Seizure Disorder	☐	☐
Cancer	☐	☐
Type _____		
Radiation Therapy	☐	☐
Chemotherapy	☐	☐
Multiple Myeloma	☐	☐
Pheochromocytoma	☐	☐
Insulinoma	☐	☐

1. **Have you ever had a contrast/ X-ray dye injection?** ☐ YES ☐ NO

   a. If yes, have you ever had a reaction to IV contrast? ☐ YES ☐ NO

   If yes, please report the type of reaction:
   ☐ Rash, Hives ☐ Nausea, Vomiting
   ☐ Swelling: eyes, face ☐ Shortness of breath
   ☐ Other _____

   Have you been premedicated? ☐ YES ☐ NO

2. Is there any possibility that you could be pregnant? ☐ YES ☐ NO

   Last menstrual period: _____
3. Are you breast feeding? ☐ YES ☐ NO
4. Do you take Glucophage, Glucovance, Metaglip, Advandamet, Actoplus-met, or Metformin? ☐ YES ☐ NO
5. Please list all medications you are presently taking:

   _____

   _____

   _____
6. Please list all previous surgery:

   _____

   _____

   _____

Patient Signature _____Date_____

For Office Use Only

Identified by: _____ Method: Verbal (name)_____
DOB _____ Other _____
I have reviewed the prescription and this form.
Technologist's Signature _____

Kba 10/07