

## CT CONTRAST QUESTIONNAIRE

NAME: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: Male  Female

**CT Scanning involves the use of x-rays. Many CT examinations involve you having an injection of a contrast medium (dye).  
Please answer the following questions prior to your examination:**

	YES	NO	Radiographer Use Only
Have you ever had an injection of contrast medium before?	<input type="checkbox"/>	<input type="checkbox"/>	
If YES, did you experience any problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have allergies that require treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a history of asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have hyperthyroidism?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have heart failure?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have diabetes mellitus?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a history of renal disease/kidney problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had previous renal surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a history of proteinuria?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have gout?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take any of the following drugs:	<input type="checkbox"/>	<input type="checkbox"/>	
• Metformin for the treatment of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
• Interleukin 2	<input type="checkbox"/>	<input type="checkbox"/>	
• Non-steroidal anti-inflammatory drugs	<input type="checkbox"/>	<input type="checkbox"/>	
• Aminoglycosides	<input type="checkbox"/>	<input type="checkbox"/>	
• Beta-blockers	<input type="checkbox"/>	<input type="checkbox"/>	
Are you over 65 years old?	<input type="checkbox"/>	<input type="checkbox"/>	

### Female Patients Only

What was the first day of your last menstrual period?			
Is there any possibility that you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>	

- In the event that I require a contrast agent (dye) during this study, I consent for this to take place
- I confirm that I have answered the above questions to the best of my knowledge

Patient Signature	Date
Staff Signature	Date

Contrast Agent	Batch Number	Checked by
Amount	Expiry Date	Administered by