

# Weill Cornell Imaging at NewYork-Presbyterian

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Numbers: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: M  F

Do you have an allergy to latex?  **Yes**  **No**

Do you have an allergy to iodine?  **Yes**  **No**

Have you had a previous reaction to X-ray dye?  **Yes**  **No**

Do you have any allergies to medicines?  **Yes**  **No**

If yes, please list the medications: \_\_\_\_\_

***Do you have any of the following:***

**Known Significant Atherosclerotic Disease**  **Yes**  **No**

**Asthma**  **Yes**  **No**

**Pheochromocytoma**  **Yes**  **No**

**Kidney Disease**  **Yes**  **No**

**Last Dialysis** \_\_\_\_ / \_\_\_\_ / **20**  **Yes**  **No**

**Hay Fever**  **Yes**  **No**

**Multiple Myeloma**  **Yes**  **No**

**Collagen Vascular Disease**  **Yes**  **No**

**Sickle Cell Disease**  **Yes**  **No**

**Receiving chemotherapy in the last two months**  **Yes**  **No**

**Diabetes with known/suspected kidney dysfunction**  **Yes**  **No**

**Are you taking insulin?**  **Yes**  **No**

**Oral Diabetic Medication Glucophage?**  **Yes**  **No**

Please list medications taken regularly: \_\_\_\_\_

**Last Menstrual Cycle:** \_\_\_\_\_ **Are You Pregnant?**  **Yes**  **No** **Breastfeeding:**  **Yes**  **No**

Have you had a previous imaging scan at Weill Cornell Medical Imaging at NewYork-Presbyterian?  **Yes**  **No**

**If so, when?** \_\_\_\_\_

For what medical problems are you having this study? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_ Which side?  Left  Right

Have you had any surgery on the area to be examined?  **Yes**  **No**

List surgical procedures and dates: \_\_\_\_\_

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## CT: QUESTIONNAIRE

Your imaging procedure requires the administration of an X-ray dye/contrast (these are two commonly used names for the same thing) which helps the physician interpret your examination.

Have you ever had an injection of X-ray dye/contrast?  **Yes**  **No**

Have you ever had X-ray dye/contrast by mouth, rectum, or other body cavity?  **Yes**  **No**

Have you ever had, as a result of x-ray dye/contrast, any of the following:

**Hives:**  **Yes**  **No**

**Shortness of breath:**  **Yes**  **No**

**Fainting/Collapsing:**  **Yes**  **No**

X-ray dye/contrast is administered by either an injection through a small needle placed into your vein or by mouth, rectum, or body cavity. During the administration of the X-ray dye/contrast you may experience a feeling of warmth, which is normal and expected.

Administration of X-ray dye/contrast is quite safe. However, there is a risk of a reaction. Uncommonly (1 out of 1,000), patients develop sneezing and hives as an adverse reaction to the dye/contrast. Very rarely (1 out of 70,000), death has occurred related to an adverse response to the X-ray dye/contrast.

If you have any questions, please speak to any staff member and they will contact a physician to answer your questions.

Questionnaire Completed By:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/20\_\_\_\_\_  
Date

Questionnaire Reviewed By:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

MD/RN/PA/TECH \_\_\_\_\_  
ID Code