Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122
Please bring all completed forms to your appointment

(Office use)

CT QUESTIONNAIRE/AUTHORIZATION

Date: ____ /____ /_____ Name: _____

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

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

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

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

If yes, please list the medications: _____

_____

Do you have any of the following? (Please check all that applies):

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**

Mediport/Implanted Infusion Device ☐ **Yes** ☐ **No**

Please list medications taken regularly: _____

Last Menstrual Cycle:_____ **Are You Pregnant?** ☐ **Yes** ☐ **No** **Breastfeeding:** ☐ **Yes** ☐ **No**

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:_____

Please turn page over

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Your imaging procedure may require 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 a reaction to x-ray dye/contrast? ☐ **Yes** ☐ **No**

If YES to any of the above, did you experience any of the below:

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 place 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.

I authorize Weill Cornell Imaging at NewYork-Presbyterian, its physicians and other staff to perform the prescribed examination.

PART 1 - (sign if you are filling out a new questionnaire form)
Questionnaire Completed By:

_____ _____ _____ /_____ /20_____
Print First and Last Name | Signature | Date

(FOR OFFICE USE ONLY)
Questionnaire Reviewed By Technologist/ Nurse/ MD:

_____ _____ _____ _____ /_____ /20_____
Print First and Last Name | Signature | MD/RN/TECH | Date

If you have been seen within the last six (6) months, please sign that you've reviewed and updated the information previously answered.

PART 2 – (sign only if you have reviewed and made necessary updates to previous answers on this form)
Questionnaire Completed By:

_____ _____ _____ /_____ /20_____
Print First and Last Name | Signature | Date

(FOR OFFICE USE ONLY)
Questionnaire Reviewed By Technologist/ Nurse/ MD:

_____ _____ _____ _____ /_____ /20_____
Print First and Last Name | Signature | MD/RN/TECH | Date