

## CT QUESTIONNAIRE/AUTHORIZATION

(Office use)

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** 

(Office use)

## CT QUESTIONNAIRE/AUTHORIZATION

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 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.

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