

(office use)

FLUOROSCOPY QUESTIONNAIRE

Name: _____ Date of Exam: _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

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: _____

Please list medications taken regularly: _____

Do you have any Food Allergies? ☐ Yes ☐ No

If yes, please list what foods you are allergic to: _____

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: _____

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FLUOROSCOPY QUESTIONNAIRE

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.

Questionnaire Completed By:

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

The [Patients' Bill of Rights](#) is available for your review.

(FOR OFFICE USE ONLY)

Questionnaire Reviewed By Technologist/ Nurse/ MD:

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