PLEASANTON
DIAGNOSTIC IMAGING CENTER

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Pleasanton, CA. 94588

Tel 925.467.1400
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CT Medical History and Contrast Questionnaire

PATIENT IDENTIFICATION

Date of Service:

Do you have any of the following:

Allergies	Yes ( )	No ( )	Diabetes	Yes ( )	No ( )
Hay Fever	Yes ( )	No ( )	Kidney Problems	Yes ( )	No ( )
High Blood Pressure	Yes ( )	No ( )	Sickle Cell Disease	Yes ( )	No ( )
Heart Problems	Yes ( )	No ( )	Allergy to Contrast (Dye)	Yes ( )	No ( )

If yes to any question, please explain: _____

_____

What is your current problem/complaint?_____

_____

Have you ever had X-ray contrast media (dye) before? Yes ( ) No ( )

Do you have a known history of contrast media (dye) allergy? Yes ( ) No ( )

Do you take Metformin or Metformin containing products? Yes ( ) No ( )
(Avandamet/Fortamet/Glucophage/Glucovance/Riomet/Glumetza/Metaglip/ActoplusMet/PrandiMet/Janumet)

Have you had prior Radiation Therapy or Chemotherapy? Yes ( ) No ( )

Have you had any radiology test with IV contrast media within the past 48 hours? Yes ( ) No ( )

Please list all Medications you take: _____

_____

Please list any prior surgeries you have had: _____

_____

Technologist Notes:

Contrast Administration Documentation

Contrast Name: _____

Lot #: _____

Contrast Amount: _____ml

BUN: _____SERUM CREATININE: _____

Reviewed by (Physician):

_____

Administration site: _____

IV Needle Size: _____

Notes: _____

_____

Tech Initials:_____ Date:_____