EASTERN RADIOLOGISTS

Doctors Park | 252.752.5000 | Mon–Fri 7am–6pm
Kinston | 252.527.7077 | Mon–Fri 8am–5pm
252.752.5000 | easternrad.com

Patient Name _____ DOB ___ /___ /___ Date ___ /___ /___ MRN _____

QUESTIONNAIRE: CONTRAST

Have you ever had contrast (X-ray dye) such as for a CT scan, kidney X-ray or heart catheterization? YES NO

Have you ever had an allergic reaction to contrast (itching, hives, swelling, shortness of breath, sneezing)? YES NO

Are you allergic to any foods or medications? YES NO
If so, please list them: _____

Have you ever had an anaphylactic (life threatening) reaction to any foods or medications? YES NO
If so, please list them: _____

Do you have asthma or use inhalers? YES NO

Did you take prednisone (a pill) last night and this morning for this test? YES NO

Are you diabetic? YES NO
If so, list what medications you take for this: _____

Do you take medication for high blood pressure? YES NO

Do you have kidney disease (other than stones)? YES NO

Do you have any heart problems? YES NO

- With unstable angina
- With severe congestive heart failure
- With severe, uncontrolled arrhythmias
- Recent Heart attack (within 1 week)
- With Shock (bp>100mm Hg, pallor, tachycardia
- With Pulmonary Hypertension

Do you have any of the following...

- Sickle Cell Disease / Thalessemia? YES NO
- Pheochromocytoma (adrenal tumor)? YES NO
- Multiple Myeloma (cancer of your plasma cells)? YES NO
- HIV / AIDS, Lupus or any other Auto-Immuno Disorder? YES NO

Are you pregnant, suspect you are pregnant or nursing an infant? YES NO

Have you had anything to eat in the last 4 hours? YES NO

Have you had a barium study within the last week? YES NO

Have you had any other studies (tests) including blood / lab work in the last 3 months? YES NO

If you are having an abdomen / pelvis CT...
Did you drink any oral contrast? YES NO
If so, what time did you finish? _____

Have you ever been diagnosed with cancer? YES NO
If so, please list when and what type: _____

Have you ever had surgery? YES NO
If so, please list: _____

Do you have a pacemaker / defibrillator or neurostimulator? YES NO

Patient Signature _____ Technologists _____