Beaumont

Patient Name _____

MRN_____

	Department of Diagnostic Imaging IMAGING HISTORY QUESTIONNAIRE							
Please give the form to the receptionist when you are called for your examination. If you have any questions, ask the technologist or nurse for assistance.								
1.	. Please describe why this procedure has been ordered							
2.	Have you ever had a CT examination? Yes No if yes when where							
	Have you ever received X-ray dye (contrast media)? Examples could be for IVP (x-ray of the kidneys), IV urogram (IVU), venogram, arteriogram, heart catheterization, or CT exam. \Box Yes \Box No							
	Have you ever had a reaction or complication to the injection of contrast media? If yes, check all that apply. \Box hives \Box flushing \Box shortness of breath \Box nausea \Box wheezing \Box difficulty swallowing							
5.	If you were treated for the reaction, how were you treated? Check all that apply:							
	Have you been pre-medicated with any anti-allergic medications for today's examination? \Box Yes \Box No							
Please list previous surgeries								

PLEASE CHECK ALL THAT APPLY OR FILL IN THE BLANKS

	YES	NO		YES	NO
Have you been diagnosed with cancer What type Allergies (please list)			Myasthenia gravis		
			Systemic lupus erythematosus (lupus)		
			* Renal Transplant		
Are you currently having symptoms due to asthma? Are you now experiencing any chest pain/ pressure, dizziness, irregular heartbeat, or			* A kidney removed or have been told a kidney doesn't work?		
			* Any kidney problems?		
			Are you on Dialysis?		
shortness of breath? * diabetes			Are you taking (or have recently taken) any drugs that you have been told might		
Hypertension (high blood pressure)			damage your kidneys?		
Do you take a metformin-containing			Mastectomy (removal of breast)		
* Do you take a metformin-containing medication (i.e. Glucophage, Glucovance, Metaglip, Avandamet, other)?			Abnormal blood circulation in either arm		
* Multiple myeloma			Radiation therapy to the chest or arm		
Pheochromocytoma			Sickle cell anemia		

* Labs required for Yes answers - Metformin see back

	Patient Name								
If you are having a neck CT please fill out area below.	MRN								
I. Are you able to feel a mass or a lump? Yes No If yes, where? 2. If you have a mass or a lump, is it painful? Yes No For how long have you had it? 3. Do you have difficulty or pain in swallowing? Yes No 4. Have you had a recent history of: (check below) PLEASE SHADE AREA OF ABNORMALITY 4. Have you had a recent history of: (check below) Cold or flu Fever Cold or flu Fever Dental work or surgery Sinus infection Ear or throat infection 5. Do you have any of these symptoms? (check below) Sinus congestion Far: ache buzzing I buzzing loss of hearing Nose bleed Double vision Less F T G Have you had or alignosis of cancer or tumor? Yes No If yes, what is the primary site or diagnosis? 8. Have you had or are you having radiation-therapy? Yes No 10. Have you had or are you having radiation-therapy? Yes No									
DOCUMENTATION OF RADIOCONTRAST ADMINISTRATI	ION	N Techno	logist Us	e Only					
Pre Exam Checklist Order verification by direct order or Pre-medication given ID band verified	prescription		☐ Yes ☐ Yes trast ☐ Yes	s 🗆 No					
Laboratory Tests BUN Serum Creatinine HCG	BUN Serum Creatinine Creatinine Clearance (GFR)								
Type of IV Contrast Used Isovue 370- Injection rate Bolus tracking Amount: Contrast mL Scan Delay									
Type of Oral Contrast Used Isovue 300, mL in 900 mL water Barium (Readicat): Amount Volumen Water: Amount Other: Amount Post Exam Checklist Contrast Reaction*	Metformin Risk Factors Liver Dysfunction Alcohol Abuse Cardiac Failure Myocardial/Peripheral Sepsis/Severe Infection *Briefly describe	1							
Extravasation* EPIC documentation	*Complete appropriate repo								