

**CONTRAST MEDIA PATIENT QUESTIONNAIRE**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Type of CT: \_\_\_\_\_ Date of CT: \_\_\_\_\_

- |   | YES   | NO    |
|---|-------|-------|
| 1. Are you over age 65?   | _____ | _____ |
| 2. Have you had ever had an allergy to IV contrast, “dye”, or “iodine”? | _____ | _____ |

If yes, please list type of contrast and reaction. \_\_\_\_\_

- |   |       |       |
|---|-------|-------|
| 3. Any anaphylactic allergies                                 | _____ | _____ |
| 4. Any other radiology/diagnostic exams within past 24 hours? | _____ | _____ |

Any contrast utilized: \_\_\_\_\_

- |   |       |       |
|---|-------|-------|
| 5. Do you have diabetes?                              | _____ | _____ |
| 6. Do you have kidney disease or liver disease?       | _____ | _____ |
| Do you have 2 kidneys                                 | _____ | _____ |
| Do you have multiple myeloma, or other blood disease? | _____ | _____ |
| Do you have pheochromocytoma (type of adrenal tumor)? | _____ | _____ |
| Do you have sickle cell disease?                      | _____ | _____ |