Oregon Health & Science University
Diagnostic Imaging Services

PATIENT CONTRAST QUESTIONNAIRE AND PROCEDURE RECORD

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

PLEASE ANSWER THE FOLLOWING QUESTIONS	
Are you allergic to iodine?	☐ **Yes** ☐ **No**
Do you have any allergies? Please list all allergies: _____ _____	☐ **Yes** ☐ **No**
Do you have asthma?	☐ **Yes** ☐ **No**
Do you have diabetes?	☐ **Yes** ☐ **No**
If diabetic, do you take the medication Metformin, Glucophage® Glucovance®, Avandamet®, Metaglip®, Fortamet®, Riomet®, or Actoplus Met®?	☐ **Yes** ☐ **No**
Do you have any kidney problems (abnormal kidney function, abnormal creatinine, on dialysis, etc.)? Please describe: _____	☐ **Yes** ☐ **No**
Have you had kidney surgery, a kidney transplant, or do you have only one functioning kidney? Please describe: _____	☐ **Yes** ☐ **No**
Do you have a type of cancer called Multiple Myeloma?	☐ **Yes** ☐ **No**
Are you taking Lasix or a water pill?	☐ **Yes** ☐ **No**
Do you take medication called **Amiodarone, Cordarone, or Pacerone?**	☐ **Yes** ☐ **No**
Are you pregnant or breastfeeding?	☐ **Yes** ☐ **No**
Have you ever had a procedure in which you were given contrast (x-ray dye), such as an angiogram, arteriogram, IVP or CT?	☐ **Yes** ☐ **No**
Did you have a reaction to the contrast (x-ray dye)?	☐ **Yes** ☐ **No**
Did you take any medication for the reaction before coming today? Describe the reaction: _____	☐ **Yes** ☐ **No**
Have you had contrast (X-ray dye) injected within the last 24 hours?	☐ **Yes** ☐ **No**
Have you ever been told not to have contrast (x-ray dye)?	☐ **Yes** ☐ **No**
Have you had your blood drawn within the last 30 days? ☐OHSU ☐ Other Clinic (clinic name): _____	☐ **Yes** ☐ **No**
Are you currently on any isolation precautions?	☐ **Yes** ☐ **No**

The above information is correct to the best of my knowledge. I have read and understand the contents of this form. I had the opportunity to ask questions about the information on this form and the CT procedure I am about to have.

Date: _____ Signature of person completing form: _____

Please print your name: _____

Relationship to patient: ☐ Self ☐ Relative ☐ CT Tech. ☐ RN ☐ Physician ☐ Other: _____

Name of Imaging staff reviewing form: _____