

HOBOKEN RADIOLOGY

Providing a clearer image of health

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CT QUESTIONNAIRE

MR# _____

OFFICE USE ONLY

Patient Name: _____ D.O.B.: _____ Sex: M F

Why are you having this exam done? _____

Please list all previous surgeries: _____

Which medical illnesses do you have? _____

Please list all the medications you take: _____

List any and all allergies you have: _____

	YES	NO
ARE YOU PREGNANT OR POSSIBLY PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU ALLERGIC TO IV DYE OR CONTRAST?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU ALLERGIC TO IODINE?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU A DIABETIC?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU ALLERGIC TO SHELLFISH?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU ON RENAL DIALYSIS?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY RENAL OR KIDNEY PROBLEM?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU TAKING GLUCOPHAGE, GLUCOVANCE, AVANDAMET, METAGLIP, OR METFORMIN?	<input type="checkbox"/> *	<input type="checkbox"/>

***If yes and injected with IV Contrast discontinue use for 48 hours and contact your physician before restarting the medication.**

ARE YOU BREASTFEEDING AT THIS TIME?

DO YOU HAVE MULTIPLE MYELOMA?

DO YOU HAVE A PHEOCHROMOCYTOMA?

PATIENT SIGNATURE: _____ DATE: _____

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TECH: _____ CONTRAST: YES NO CC'S: _____ DR. _____