

Weight: \_\_\_\_\_

1. Why does your doctor want you to have this test today?  
\_\_\_\_\_

2. Are you currently under a doctor's care for: (check)

- |  |   |                                       |  |   |
|--|---|---------------------------------------|--|---|
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Dialysis     | <input type="checkbox"/> Lung Disorder       | <input type="checkbox"/> Pheochromocytoma   |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Irregular Heart Rate | <input type="checkbox"/> Pacemaker    | <input type="checkbox"/> Respiratory Failure | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Renal/Kidney Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple Myeloma    | <input type="checkbox"/> Other: _____       |

3. Please check if you have ever had any of the following X-ray tests.

- |                                     |                                      |                                     |                                       |                                      |
|-------------------------------------|--------------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> CT Scan    | <input type="checkbox"/> Heart Cath. | <input type="checkbox"/> Arthrogram | <input type="checkbox"/> Myelogram    | <input type="checkbox"/> Arteriogram |
| <input type="checkbox"/> IVP/Kidney | <input type="checkbox"/> Venogram    | <input type="checkbox"/> MRI        | <input type="checkbox"/> Other: _____ |                                      |

4. Please list any allergies you have to:

FOODS: _____	DRUGS: _____	HAY FEVER: _____
_____	_____	OTHER: _____
_____	_____	_____

5. Have you ever had a reaction to contrast media (X-ray dye/iodine)?

Yes  No If yes, please explain: \_\_\_\_\_

6. Do you take any of these medications for diabetes?  Yes  No If yes, What?

Glucophage - Metformin HCL / Glucovance - Glyburide - metformin HCL / Metaglip - (Gen. name - Glipizide/Metformin HCL)  
(Note - Do not take any of these medications for 48 hours after having x-ray done.)

7. Have you ever been diagnosed with cancer?  Yes  No

8. Please check any surgeries you have had:

- |                                       |                                   |                                      |                                  |                                 |                                  |                                   |                                 |   |
|---------------------------------------|-----------------------------------|--------------------------------------|----------------------------------|---------------------------------|----------------------------------|-----------------------------------|---------------------------------|---|
| <input type="checkbox"/> Brain        | <input type="checkbox"/> Chest    | <input type="checkbox"/> Transplant  | <input type="checkbox"/> Bladder | <input type="checkbox"/> Breast | <input type="checkbox"/> Ovaries | <input type="checkbox"/> Prostate | <input type="checkbox"/> Kidney | <input type="checkbox"/> Back (Lumbar/Thoracic) |
| <input type="checkbox"/> Sinus        | <input type="checkbox"/> Appendix | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Heart   | <input type="checkbox"/> Hernia | <input type="checkbox"/> Stomach | <input type="checkbox"/> Aorta    | <input type="checkbox"/> Neck   | <input type="checkbox"/> Uterus                 |
| <input type="checkbox"/> Other: _____ |                                   |                                      |                                  |                                 |                                  |                                   |                                 |   |

FEMALES ONLY:

9. Could you be pregnant?  Yes  No Date of last period \_\_\_\_\_ Postmenopausal:  Yes  No

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

TECHNOLOGIST USE ONLY Exam: \_\_\_\_\_

Emergency Medication Available  Yes  No

Time Out (Patient, Procedure, Site, Position, Equipment verified)  Yes  No

Procedure and Possible Side Effects Explained to Patient

Contrast Volume/Type: \_\_\_\_\_

Injection Time: \_\_\_\_\_ Amount of Fluoro. \_\_\_\_\_

Patient Tolerated: \_\_\_\_\_

Technologist Signature: \_\_\_\_\_



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## RADIOLOGY QUESTIONNAIRE

White Copy: Medical Records

Yellow Copy: Patient Folder