Intravenous Iodinated Contrast Screening Questionnaire

1. Have you ever had an x-ray examination that required the injection of an intravenous Contrast material ("x-ray dye")? For example: CT scan, IVP, or heart catheterization...........**YES** **NO**

   If yes, did you have an unusual reaction to the intravenous contrast material (rash, difficulty breathing, nausea, or any other problems)?..**YES** **NO**

2. Do you have any allergies to medications or foods?..**YES** **NO**
   Please list:

3. Do you have asthma?..**YES** **NO**
   If yes and you take a medication for it, please list the medication.

4. Do you have emphysema or other lung disease?..**YES** **NO**
   Please explain:

5. Do you have any heart problems, angina, or have you had heart surgery?.................................**YES** **NO**
   Please explain:

6. Do you have any kidney problems or have you had kidney surgery?...**YES** **NO**
   Please explain:

7. Do you have diabetes (high blood sugar)?...**YES** **NO**

8. Are you taking Metformin, Glucophage, or Glucovance for your diabetes?...............................**YES** **NO**

9. Are you or could you be pregnant?..**YES** **NO**

10. Are you breast feeding?...**YES** **NO**

11. Are you having any other test today?...**YES** **NO**

12. Have you been given a specific diagnosis?..**YES** **NO**
    What is it?

13. What medical conditions (pneumonia, emphysema, cancer), treatment (medication, radiation, or chemotherapy) or surgery have you had, and when?

14. In case of an emergency, please call: Name:______________________ Phone number:______________

Patient's Name:______________________ **Date of Birth:**___________ **Today's Date:**______________