LUMINA
IMAGING AND DIAGNOSTICS

**Name:**

**DOB:**

**Height: _____ Weight: _____**

# CT Patient Questionnaire for Contrast Media

**Your physician has requested an exam that requires the use of intravenous and/or oral contrast. While the contrast is generally safe, all medications may be associated with adverse reactions. The following questions are to help identify patients who may be at a higher risk for reactions or need additional screening prior to receiving contrast.**

Do you have any allergies? If so, please list: Yes No

| Allergy: | Describe Reaction: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Yes No Any chance of pregnancy Last menstrual period: _________

Yes No Have you ever received IV contrast and/or oral contrast before?

Yes No Have you had a previous reaction to CT contrast?

If yes, please describe: _____

_____

Yes No Are you aware of any reason you should not have IV or oral contrast today?

**Please indicate if you have any of the following medical conditions:**

Yes No Breast feeding

Yes No History of diabetes

Yes No History of chronic kidney disease, dialysis or renal transplant

Yes No History of asthma or inhaler use

Yes No History of hypertension requiring medical therapy

Yes No Congestive heart failure

Yes No Metformin or Metformin-containing drug use (i.e. Glucophage, Glucovance, Actoplus MET, JANUMET, Prandimet, Avandamet, Metaglip, etc.)

**Signature of person completing form: _____ ____ Date: _________**

Relationship to patient: _____

For official use only

Current eGFR: _____mL/min/1.73m$^2$ Technologist initials _____