

## PATIENT HISTORY FOR CT AND X-RAY CONTRAST MEDIA

Patient Name: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

### 1. Please indicate if you have one of the following\*:

- History of kidney disease as an adult or family history of kidney problems
- History of kidney transplant
- Diabetes
- Paraproteinemia syndromes or diseases (e.g. myeloma)
- Collagen vascular disease (e.g. Lupus)
- Recent contrast study (e.g. within the last 7 days) \_\_\_\_\_
- Any surgeries? If yes, please list: \_\_\_\_\_
- Sickle cell disease

### Please indicate if you are taking certain medications:

- Metformin or metformin-containing drug combinations (Metformin, Avandamet, Glucophage, Glucophage XR, Glucovance)
- Regular use of nephrotoxic antibiotics, such as aminoglycosides, or non-steroidal anti-inflammatory drugs (e.g., Advil, Motrin, Aleve, etc)

**\*If you checked any of the boxes above, please inform your technologist. You may require special instructions and/or further blood test(s) to assess your kidney function prior to receiving IV contrast media.**

2. Have you ever had an allergic reaction to IODINE/IV CONTRAST? (Circle one) YES NO

\*If "YES", please describe \_\_\_\_\_

**\*If "YES", based on your reply, you may require pre-medication prior to receiving IV contrast, no IV contrast, or alternative imaging.**

### 3. Do you have a history of the following medical conditions?

- Asthma (if you have active asthma, bronchospasms, or bronchitis requiring treatment)
- Cardiac Disease (angina, congestive heart failure, aortic stenosis, primary pulmonary hypertension, severe but well compensated cardiomyopathy)
- History of allergic (anaphylactic) reaction to one or more allergens
- Allergies to any medications, medical tape, etc. \_\_\_\_\_
- Reason for your exam – please list your current symptoms. \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT INFORMATION REGARDING IODINATED CONTRAST INJECTIONS

Your physician has ordered an examination that requires an injection of a contrast agent that contains iodine into your vein or joint space. This contrast agent will demonstrate any normal/abnormal features of organs/anatomy within the body that would otherwise not be visible without the contrast agent. The contrast will then be eliminated from your body by the kidneys. During this elimination process the kidneys, ureters, bladder and urethra become visible on the CT images and the radiographs. This test is not a treatment and is for diagnostic purposes only. Modern contrast agents have been shown to be safe, but there is still a risk of allergic reaction from the injection just like any other injection of medicine.

**IF YOU HAVE ANY ALLERGIES TO IODINE OR HAVE HAD ANY ALLERGIC REACTIONS TO CONTRAST IN THE PAST, PLEASE INFORM THE TECHNOLOGIST PRIOR TO THE EXAM.**

Once the contrast is injected you might experience a warm feeling, a metallic taste in your mouth or nausea. This is normal. Occasionally vomiting can occur and *rarely*, kidney failure. Allergic reactions can include hives, rash, or difficulty breathing. The technologist will constantly observe you for any reactions, but please let the technologist know if you start to experience any of the above.

**Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

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## CT/X-RAY PREGNANCY CONSENT FORM

This form must be completed for/by all women between 11 and 50 years of age. The radiation used in X-ray and Computed Tomography (CT) may be harmful to an unborn child. To help prevent the accidental irradiation of an unrecognized pregnancy and in accordance with national standards, we require the following information from female patients of child bearing age. If any of the information below indicates even a remote possibility of pregnancy, your referring physician will be asked to order a urine or serum pregnancy test prior to any imaging. Please answer the following questions:

1. Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Unsure: \_\_\_\_\_
2. First day of your last menstrual cycle: \_\_\_\_\_
3. Birth control measures:  
Birth control pill \_\_\_\_\_ Foam \_\_\_\_\_ IUD \_\_\_\_\_ Condoms \_\_\_\_\_  
Hysterectomy \_\_\_\_\_ Norplant \_\_\_\_\_ Tubal ligation \_\_\_\_\_ Diaphragm \_\_\_\_\_ Other \_\_\_\_\_
4. If "no" or "none of the above" were answered in question 3, have you had any sexual activity since your last menstrual period that may put you at risk of pregnancy? Yes \_\_\_\_\_ No \_\_\_\_\_

I, (patient's name/guardian's name) \_\_\_\_\_, have been fully informed of the risks involved in radiating a first trimester pregnancy and assume the responsibility for any consequences from the procedures I am about to have. I also understand that I will not hold University Imaging, the employees of the facility and American Radiologist Associates Radiologists responsible for any potential harm to myself or unborn child.

**Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_**