

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Department of Radiology CT QUESTIONNAIRE (Outpatient)	BIRTHDATE NAME REG NO
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Date: _____

Form completed by:
 Patient Family (relationship): _____ UMHHS Staff Other: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:	YES	NO	UNKNOWN
1. Any IV contrast (X-ray dye) allergy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. A severe food or medication allergy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Asthma, wheezing or breathing problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes to questions 1, 2 or 3 did you receive a steroid/Benadryl prep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you pregnant or breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Chest pain, angina or heart failure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Medical conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Kidney transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Kidney disease or Kidney failure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Myasthenia gravis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Thyroid cancer or overactive thyroid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Taking Metformin (e.g. Glucophage, Glucovance, Avandamet, Metaglip)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes to question 7 did you receive instructions about managing your Diabetes while you are off the Metformin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Taken Interleukin-2 in the past 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Can you stand without assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you need an interpreter? (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you hearing impaired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Other communication issues: (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please note: all body piercing/jewelry/hairpins and any removable metal containing items or clothing must be removed before entering the CT scanner

Height: _____ ft _____ in Weight: _____ lbs

_____ Print Name _____ Signature of person completing questionnaire _____ Date

HEALTHCARE PROVIDER / NURSE TO COMPLETE SECTION BELOW				
Order	Completed	Staff Name (print)	Date	Time
Peripheral IV Placed: (specify location and size)				
Serum Creatinine checked (indicate results)				
BUN checked (indicate results)				
Provided information sheet if patient is taking Metformin				
Reviewed questionnaire with patient				
Comments:				