MICHIGAN MEDICINE Radiology **CT Questionnaire (Outpatient)**	MRN: NAME: BIRTHDATE: CSN:

Date: _____/_____/___________ (mm/dd/yyyy)

Form completed by: ☐ Patient ☐ Family (relationship): _______________________
☐ UMHHS Staff ☐ Other (specify): ___________________________________

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:	**YES**	**NO**	**UNKNOWN**
1. Any IV contrast (X-ray dye) allergy?	☐	☐	☐
If yes to question #1, did you receive a steroid / Benadryl prep to prepare for today's exam?	☐	☐	☐
2. Are you pregnant or breast feeding?	☐	☐	☐
3. Chest pain, angina or heart failure?	☐	☐	☐
These medical condition related questions will be used to prescribe contrast media for your exam:			
• Kidney transplant?	☐	☐	☐
• Kidney disease or Kidney failure?	☐	☐	☐
• Thyroid cancer or overactive thyroid?	☐	☐	☐
• Taken Interleukin-2 in the past 2 weeks?	☐	☐	☐
• Do you have a colostomy/ileostomy?	☐	☐	☐
4. Do you have a subcutaneous insulin infusion pump or a continuous glucose monitoring device?	☐	☐	☐
5. Do you have a Power Port?	☐	☐	☐
6. Can you stand without assistance?	☐	☐	☐
7. Do you need an interpreter? (specify language):	☐	☐	☐
8. Are you deaf or hard of hearing?	☐	☐	☐
9. Other communication issues (specify):	☐	☐	☐

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. _________ inch(es) Weight: __________ lbs.

Person Completing Questionnaire: ____ _____/_____/________
Printed Name Date (mm/dd/yyyy)

HEALTHCARE PROVIDER / NURSE TO COMPLETE SECTION BELOW				
Order	Completed	Staff Name (print)	Date	Time
Peripheral IV Placed (specify location and size):	☐			
Serum Creatinine checked	☐			
BUN checked	☐			
Provided information sheet if patient is taking Metformin	☐			
Reviewed questionnaire with patient	☐			
Pregnancy Test performed? ☐ No ☐ Yes (indicate result) ☐ Positive ☐ Negative				
Comments:				