

## CT Virtual Colonoscopy

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Surgical History: (please circle all that apply)

Gallbladder	Liver	Stomach	Cervical Spine
Hysterectomy	Spleen	Thyroid	Thoracic Spine
Hernia	Colon	Kidney	Lumbar Spine
Chest/Lung	Appendix	Neck	Vascular

Other: \_\_\_\_\_

Do you have a family history of heart disease?  Yes  No

Do you have a history of heart disease?  Yes  No

If yes, please describe: \_\_\_\_\_

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Do you have a history of cancer?  Yes  No

If yes, please describe: \_\_\_\_\_

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Do you have a history of diabetes?  Yes  No

Do you have a history of smoking?  Yes  No

Are you currently smoking?  Yes  No

Have you quit smoking?  Yes  No

If yes, How long ago? \_\_\_\_\_

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CT Technologist:

\*For all screening procedures, please email ARA at [ctaylor@americanrad.com](mailto:ctaylor@americanrad.com) so the radiologists do not charge the patient a separate reading fee.

## OUTPATIENT QUESTIONNAIRE/ASSESSMENT RADIOLOGY & MEDICAL IMAGING DEPARTMENT

### ***Patient Information and History***

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_

Exam(s) being done today: \_\_\_\_\_

Briefly explain to the best of your knowledge the reason for this exam: \_\_\_\_\_  
\_\_\_\_\_

What is the primary language spoken? \_\_\_\_\_

- 1. Do you need assistance walking and/or standing?  Yes  No
- 2. Are you "at risk" of falling?  Yes  No
- 3. Have you had any recent falls?  Yes  No

Date of recent fall: \_\_\_\_\_ Briefly explain: \_\_\_\_\_  
\_\_\_\_\_

- 4. Is there anyone with you today?  Yes  No
- 5. Do you have any known allergies to latex products?  Yes  No
- 6. Are you allergic to any medications?  Yes  No  
If yes, what type(s)?: \_\_\_\_\_
- 7. Are you diabetic?  Yes  No

### ***X-Ray, CT and Ultrasound patients:***

- 8. Have you had any chemotherapy?  Yes  No
- 9. Have you had any radiation therapy?  Yes  No
- 10. Have you had any type of cancer?  Yes  No

Type of cancer: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_

11. Please list all surgical procedures: \_\_\_\_\_  
\_\_\_\_\_

12. Have you had any previous imaging studies?  Yes  No \*If yes, please indicate below:

<u>Type of Study</u>	<u>Date</u>	<u>Facility</u>
Radiograph (X-Rays)	_____	_____
Computed Tomography (CT Scan)	_____	_____
Nuclear Medicine (Bone Scan)	_____	_____
MRI (Magnetic Resonance Imaging)	_____	_____
Ultrasound (Sonogram)	_____	_____
Other	_____	_____

**BAYLOR UNIVERSITY MEDICAL CENTER**  
DALLAS, TEXAS



51221 (Rev. 06/09)

**OUTPATIENT QUESTIONNAIRE  
& ASSESSMENT**

RAD-024

**OUTPATIENT QUESTIONNAIRE/ASSESSMENT  
RADIOLOGY & MEDICAL IMAGING DEPARTMENT**

***Individualized Patient Care***

1. What is one thing I can do for you to make sure you receive **very good** care today?

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2. Are there any **special needs/considerations** that we should know about?

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***Medication List***

**Please list all medications you are currently taking:**

Date	Medication Name	Dose	Frequency

\_\_\_\_\_  
Patient / Patient Caregiver Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Signature (i.e. Medical Assistant)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinical Signature (i.e. Technologist)

\_\_\_\_\_  
Date

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**OUTPATIENT QUESTIONNAIRE  
& ASSESSMENT**

**BAYLOR HEALTH CARE SYSTEM  
PATIENT HISTORY FOR CONTRAST MEDIA**

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ 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
- History of liver disease
- Diabetes
- Paraproteinemia syndromes or diseases (e.g. myeloma)
- Collagen vascular disease (e.g. Lupus)
- Recent contrast study (e.g. within the last 7 days)
- Recent surgeries? If yes, please list: \_\_\_\_\_
- Sickle cell disease

Certain medications:

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

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

**2. Have you ever had an allergic reaction to intravenous contrast (e.g. iodine, gadolinium)?**  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, bronchospasm, or bronchitis requiring treatment, please inform your technologist **now**)
- Cardiac Disease (angina, congestive heart failure, aortic stenosis, hypertension, primary pulmonary hypertension, severe but well compensated cardiomyopathy)
- History of allergic (anaphylactic) reaction to one or more allergens

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient, Parent or Guardian)

**To be filled out by the technologist performing your exam**

\_\_\_\_\_ Exam Performed Per Protocol      \_\_\_\_\_ Exam Performed Per Physician / Name: \_\_\_\_\_

Contrast IV - Type/Amount/Rate/Site: \_\_\_\_\_ Contrast Oral - Type/Amount: \_\_\_\_\_

Creatinine: \_\_\_\_\_ Result Date: \_\_\_\_\_ Estimated Glomerular Filtration Rate: \_\_\_\_\_

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

**BAYLOR HEALTH CARE SYSTEM**



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**PATIENT HISTORY FOR CONTRAST MEDIA**