

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?

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

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

Patient Name: _____ Date of birth: _____ Height: _____ Weight: _____

In order to assess your risk of complications and reduce risk for a contrast media allergic reaction please complete sections 1-3 below:

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: _____ Time: _____
(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: _____ Time: _____

BAYLOR HEALTH CARE SYSTEM



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PATIENT HISTORY FOR CONTRAST MEDIA