

IODINATED CONTRAST QUESTIONNAIRE

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PATIENT NAME: _____ DATE: _____

Have you ever had an (Iodine) contrast injection for any test? Yes No
Did you have any reaction to the injection? Yes No
If you answered yes to the above questions, what type of reaction was it?
Hives (rash) Itchy eyes Throat tightness Other _____

Do you have any Allergies? YES NO

Environment

Dust _____
Pet hairs _____
Detergents _____
Fabrics (wool) _____
Hay Fever _____
Other _____

Food

Dairy _____
Meats _____
Vegetables _____
Grains _____
Shellfish _____
or Seafood _____

Medications

Antibiotics or
Penicillin _____
Other _____

Do you have asthma or other lung conditions now or as a child? Yes No

Do you have any rashes or skin conditions now or as a child? Yes No

Have you been given medicine to take prior to this test? Yes No

If yes, what medicine and when was it taken? _____

Do you have any medical conditions now or as a child? YES NO

Cancer Heart Problems High Blood pressure Lung Kidney

Do you take any medication? YES NO

Are you DIABETIC? Yes No Do you use INSULIN? Yes No

Do you take PILLS for your diabetes? Yes No

Do you take GLUCOPHAGE? Yes No

Did you eat or drink anything in the last 4 hours? Yes No

If yes, what did you eat/drink? _____

Is there any possibility you may be pregnant? Yes No

Previous surgical procedures? _____

Any previous x-rays for this problem? Yes No

I UNDERSTAND THAT MEDICARE/MY INSURANCE MAY NOT PAY FOR NONIONIC CONTRAST.

PATIENT SIGNATURE

DATE