MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
LOCAL FORM TITLE *(Optional)*	

NAVAL HOSPITAL LEMOORE
RADIOLOGY DEPARTMENT
COMPUTED TOMOGRAPHY CONTRAST RISK QUESTIONNAIRE

PLEASE FILL OUT THE FOLLOING QUESTIONNAIRE SO THAT WE MAY BETTER SERVE YOU:

Have you ever had a reaction to previous contrast (iodine dye) administration, such as itching, hives, swelling, difficulty breathing, unconsciousness, shock, or prolonged vomiting? ☐ YES ☐ NO
(Patients that answer "YES" should receive steroid premedication and LOCM.)

Do you have asthma? ☐ YES ☐ NO
Do you have multiple allergies (excluding allergies to foods)? ☐ YES ☐ NO
Please write allergies:
Do you have congestive heart failure, pulmonary hypertension, ☐ YES ☐ NO
heart arrhythmias, unstable angina, or have you recently had a heart attack? ☐ YES ☐ NO
Do you have Sickle Cell disease or other blood disorder such as thalassemia? ☐ YES ☐ NO
(Patients that answer "YES" to any of the above questions should receive LOCM, premedication is not necessary)

Do you have diabetes mellitus? ☐ YES ☐ NO
Do you have renal (kidney) insufficiency? ☐ YES ☐ NO
Are you currently taking Metformin (Glucophage, Glucophage XR), Metformin/Glipizide (Metaglip), Metformin/Rosiglitazone (Adandamet) or Metformin/Pioglitazon (Actoplus Met) for non-insulin-dependent diabetes? ☐ YES ☐ NO
(Patients that answer "YES" to any of the above questions should have their renal function screened and receive LOCM as indicated Premedication is not necessary. Patients receiving Glucophage must STOP the medication for at least 48 hours following the examination and see their physician before restarting it.)

Please mark any of the following that apply to you:

☐ 50 years of age or older
☐ Have gout
☐ High blood pressure
☐ Dehydrated
☐ Have multiple myeloma
☐ Received intravenous contrast in the last 48 hours

(Patients that answer "YES" to any of the above questions should have their renal function screened and receive LOCM as indicated.)

Do you have renal (kidney) failure? ☐ YES ☐ NO
Have you ever received Interleukin-2 Immunotherapy? ☐ YES ☐ NO
Do you have a history of thyroid malignancy? ☐ YES ☐ NO
(Patients that answer "YES" to any of the above questions should not receive intravenous contrast.)

HOME PHONE _____ AGE: _____ GFR: _____
HEIGHT: _____ CREAT: _____
WORK PHONE _____ WEIGHT: _____ DATE DRAWN: _____

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	