RADCARE
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Questionnaire Computed Tomography (CT)

To be able to evaluate your potentially increased risk, we ask that you kindly answer the following questions.

Name of patient

Date of birth | Room Nr. | Weight (kg) | Height (cm) | Krea/GFR

Have you ever undergone any of the following examinations?	**Yes** ☐	**No** ☐
Kidney X-rays (i.v. urography)	☐	☐
Computed tomography scan (CT)	☐	☐
Depiction of the leg veins (phlebography)	☐	☐
Blood vessel X-rays (angiography/cardangiography)	☐	☐

Did you experience any adverse reactions after the administration of contrast medium?	☐	☐
Nausea/vomiting/gagging	☐	☐
Asthma attack/dyspnoea	☐	☐
Skin rash	☐	☐
Seizures, unconsciousness	☐	☐
Chills	☐	☐

Have you been diagnosed with any of the following diseases?	☐	☐
Asthma	☐	☐
Allergies requiring treatment	☐	☐
Of the heart	☐	☐
Of the kidneys/adrenal gland	☐	☐
Of the thyroid Is surgery of the thyroid gland scheduled?	☐	☐
Diabetes If yes, what kind of medication?	☐	☐
Kahler's disease (multiple myeloma)	☐	☐

Do you suffer from claustrophobia?	☐	☐
I agree to receive an injection with a contrast medium.	☐	☐
For female patients: Is there a possibility that you might be pregnant?	☐	☐

I confirm that I have read and understood the text and that I have answered the questions concerning my person to the best of my knowledge. I consent to the conduct of the proposed CT examination. My questions have been adequately answered during a personal conversation.

Date/time	Patient's signature or legal guardian's signature	Physician's name and signature	Med. tech. employee's name and signature