MEDICAL HISTORY QUESTIONNAIRE

Computed Tomography Department – Patient information and informed consent

Surname, first name, date of birth

_____

Phone.: _____ email: _____ Family Doctor_____

Have you been given an iodinated X-ray contrast medium in the past? ☐ yes ☐ no
(e.g. for examination of the kidneys, examinations with cardiac catheter, vascular examinations, CT)

Did you notice any adverse effects following administration of the X-ray contrast medium? ☐ yes ☐ no
(e.g. nausea, skin rash, itching, sneezing attacks, shortage of breath, circulatory disorders or similar)

Do you have any known allergies? (e.g. iodine, penicillin, cortisone, plasters, latex, nickel, ☐ yes ☐ no
mercury, fructose intolerance) **If yes, please specify.** _____

Has the part of the body to be examined today also been examined in the past (X-rays, CT, MRI, ☐ yes ☐ no
nuclear medicine, PET)? Name of the surgery/hospital: _____

Do you suffer from a known thyroid hyperfunction? ☐ yes ☐ no
Has Graves' disease or thyroid autonomy been diagnosed (thyroid disorders)? ☐ yes ☐ no
Do you take thyroid medication? ☐ yes ☐ no
If yes, please specify. _____
Is a scheduled examination of the thyroid due soon? ☐ yes ☐ no
If yes, please state when. _____
Have y ou undergone thyroid surgery or received radioiodine therapy? ☐ yes ☐ no

Do you take anti-diabetic pills? ☐ yes ☐ no
If yes, please specify. _____
Did you stop your medication.

Do you have a known **renal dysfunction**? ☐ yes ☐ no

Do you have a known plasmacytoma/MGUS (monoclonal gammopathy)? ☐ yes ☐ no

Do you take any anti-coagulant medication? (e.g. Marcumar or ASS) ☐ yes ☐ no

Do you have an infectious disease (e.g. hepatitis, HIV, etc.)? ☐ yes ☐ no
If yes, please specify. _____

You are entitled to a copy of this medical history questionnaire. (Under Section 630 e, sub-section 2, sentence 2, BGB)
☐ I do not require a copy of this medical history questionnaire. ☐ I would like a copy of this medical history questionnaire.

I do not have any further questions, feel that I have been properly informed and have had sufficient time for consideration. I herewith consent to the planned examination. I also agree to administration of a contrast medium, if required.

Weight (kg): _____ Height (cm): _____ Age: _____ Date/Signature _____
(legal representative, if necessary)

For female patients:
Are you still breast-feeding? ☐ yes ☐ no

I herewith confirm that I am currently not pregnant and am not aware of a pregnancy.

Last period: _____Date/Signature _____

Please note the information overleaf!

Important – Please read this information carefully!

Dear Patient,

Your doctor has referred you for an examination for which a contrast medium may be required. Administration of the contrast medium as such has no effect on your ability to drive a motor vehicle.

You rest on an examination table which slowly moves into the round opening of the CT scanner. This opening is fairly large, so there is no need for you to feel boxed in. Just lie calmly and relax as the scan proceeds. Try not to move and follow the instructions for breathing. Some scans require that a contrast medium be injected into your vein in order to obtain diagnostically conclusive images. This may cause you to experience a slight but harmless feeling of warmth and a different taste on your tongue which, however, disappears within seconds. For abdominal scans, you will additionally be asked to drink a solution containing contrast medium some time before the scan.

X-ray contrast media contain iodine. Some patients are allergic to contrast media and therefore cannot be examined in this way. Allergic reactions are very rare and include, for example, nausea, vomiting, skin reactions or major circulatory reactions. X-ray contrast medium similarly must not be given to patients with thyroid hyperfunction or renal dysfunction.

We want to minimize the examination risk for you where possible. For this reason, we use extremely modern contrast media to which allergic reactions are very rare. If you have a tendency towards certain allergies, we will additionally inject other medication for your own safety, which may induce a slight, temporary sleepiness. Since you will be temporarily unfit to drive in such a case, you must not drive a motor vehicle or motor cycle or operate potentially dangerous machines during the next 2 hours.

We will remain in your immediate vicinity throughout the examination. Please inform us of everything that disquiets you, particularly if you notice any of the following symptoms: sneezing or itching, wheals, coughing, difficulty in breathing, dizziness, nausea or pain in the area of the hypodermic needle.

Unless instructed otherwise by your doctor, you should drink plentifully after such examinations in order to speed up discharge of the contrast medium. Inform your doctor immediately if you suddenly feel itchiness, sneezing attacks, pain, nausea, diarrhoea or other bodily symptoms either on the day of the examination or on the following days.

von _____ bis _____

This part to be completed by medical personnel!

	_____KV	_____ml ☐ Accupaque
	_____mAs	☐ Iopamidol
	_____Aufnahmen	☐ o. Barium
	_____Filme	☐ o. KM
	_____CD	
	_____QR-Code	
	_____PP	

Notizen:

Arzt: _____