DIAGNOSE ZENTRUM BRIGITTENAU

**CT**

**[Patientenname], [Geb.datum]**

In order to determine possible side effects, we kindly request to **answer the following questions**:

| | |
|---|---|
| **Weight: ……kg** **Height: ……cm** | |
| **Do you have a cardiac pacemaker?** | ☐ yes ☐ no |
| **Have you ever undergone any of the following examinations?** | |
| • Kindey X-Ray (i.V. urography) | ☐ yes ☐ no |
| • Depiction of the leg veins (phlebography) | ☐ yes ☐ no |
| • Blood vessel X-Ray (angiography/cardangiography) | ☐ yes ☐ no |
| • Computed Tomography Scan (CT) | ☐ yes ☐ no |
| **Did you experience any adverse reactions after the administration of the contrast medium?** | ☐ yes ☐ no |
| • Nausea / vomiting/ gagging | ☐ yes ☐ no |
| • Asthma attack/ shortness of breath (dyspnoea) | ☐ yes ☐ no |
| • Skin rash | ☐ yes ☐ no |
| • Seizures, unconsciousness | ☐ yes ☐ no |
| • Chills | ☐ yes ☐ no |
| • Others: ……..……..…… | |
| **Have you been diagnosed with any of the following diseases?** | |
| • HIV or Hepatitis C | ☐ yes ☐ no |
| • Asthma? | ☐ yes ☐ no |
| • Allergies requiring treatment? | ☐ yes ☐ no |
| • Of the heart? | ☐ yes ☐ no |
| • Of the kindeys / adrenal gland? | ☐ yes ☐ no |
| • Of the thyroid? | ☐ yes ☐ no |
| • Kahler's disease (multiple myeloma)? | ☐ yes ☐ no |
| • Diabetes? | ☐ yes ☐ no |
| • Which medications are you taking for the conditions mentioned above? ……..……..……..……..……..…… | |
| • Medications containing metformin should be discontinued 48 hours before the examination. | |
| • Calcium antagonists' should be discontinued 72 hours before the examination, after consulting with the treating physician." | |
| **For female patients:** | |
| **Is there a possibility that you might be pregnant?** | ☐ yes ☐ no |
| **Are you currently breastfeeding?** | ☐ yes ☐ no |

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

Date

**Signature of the patient or legal guardian**

DIAGNOSE ZENTRUM BRIGITTENAU

**CT**

**[Patientenname], [Geb.datum]**

[redacted]

| | |
|---|---|
| **Initial examination?**<br>• Therapy since the last examination: ……..…….……..……<br>• Previous findings available?<br>• Have previous images been uploaded? | ☐ yes ☐ no<br>☐ yes ☐ no<br>☐ yes ☐ no<br>☐ yes ☐ no |
| **Trauma?**<br>when ……..…… what ……..…… | ☐ yes ☐ no |
| **Tumor?**<br>☐ operated on ……..…….<br>**Therapy?**<br>☐ chemo ……..... ☐ immuno …….. ☐ hormone ……<br>☐ radiation ……. ☐ antibody ……..... ☐ other ……..... | ☐ yes ☐ no<br><br>☐ yes ☐ no |
| **Have you had kidney or adrenal surgery?**<br>☐ cyst……..... ☐ dialysis…….. ☐ double kidney……<br>☐ stone……. ☐ insufficient……. ☐ micro/macrohematuria…… | ☐ yes ☐ no |
| **Heart surgery?**<br>☐ Stent ☐ Bypass ☐ Pacemaker | ☐ yes ☐ no |
| **Have you had thyroid surgery?**<br>☐ hashimoto …… ☐ resection …… ☐ partialresection …<br>☐ adenom …… ☐ struma …… ☐ euthyrox ……<br>☐ thiamazol …… ☐ thyrex …… ☐ Others. ……..... | ☐ yes ☐ no |
| **Do you smoke?**<br>How many? ……..…… When did you stop? ……..…… | ☐ yes ☐ no |
| Appendectomy<br>Cholecystectomy<br>Hysterectomy<br>Oophorectomy<br>Prostatectomy | ☐ yes ☐ no<br>☐ yes ☐ no<br>☐ yes ☐ no<br>☐ yes ☐ no<br>☐ yes ☐ no |

**Vom DZB auszufüllen**:

Unterschrift Arzt/Ärztin

Unterschrift MTD

Blutbefund: Krea: ..... ml/dl GFR: ..... TSH: ..... µU/ml

Datum Blutbefund: .....

KM-Allergie ☐ Ja ☐ Nein Prophylaxe: .....

Venflon: ☐ Ja ☐ Nein gelegt von: .....

KM: .....