BOCA RATON
REGIONAL HOSPITAL

IMAGING SERVICES
PATIENT QUESTIONNAIRE
FOR CORONARY CT ANGIOGRAM

Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Allergies: _____

Have you had a previous reaction to contrast material (iodine)? Yes No

If yes, what was the reaction? _____

When was the last time you ate or drank something? _____

Have you take any stimulants in the last 24 hours? (caffeine, decongestives) _____

Do you have a history of? (Please circle Yes or No)

Yes No Asthma/COPD Breathing problem type:
If yes, how many inhalation treatments per day? _____

Yes No Do you smoke?
If yes, ____ packs per day for ____ years. Quit date _____

Yes No High cholesterol

Yes No Diabetes

Yes No High blood pressure

Yes No Family history of heart attack: Age ? _____

Yes No Kidney disease

Yes No Sickle cell disease

Yes No Multiple myeloma

Yes No Do you take glucophage, glucovance, metaglip, avandamet or other Metformin containing drug? If you do, hold medication for 48 hours or as M.D.

Yes No Do you have any known coronary artery disease (i.e., status post angioplasty, stent or CABG/bypass surgery)? When? _____

Yes No Have you ever had a heart attack? If yes, when? _____

Yes No Have you had a cardiac catheterization (angiogram)? If known, when, where and results: _____

Yes No Do you presently have chest pain? If yes, please describe _____

_____

Yes No Is there any chance you could be pregnant?

Yes No Have you taken any erectile dysfunction drugs such as Viagra, Levitra, Cialis, Revatio or a similar medication recently?

List all prescribed medication(s):

Explanation about the nature of my procedure has been discussed with me. My questions have been answered and I consent to receive the contrast agent.

Signature of Patient/Guardian: _____ Date: _____

Signature of RN: _____ Date: _____

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PLACE IN PATIENT'S RECORD

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