DIAGNOSE ZENTRUM BRIGITTENAU

CT

Name: .....

Date of Birth: .....

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

Height: …….kg	**Weight: …….kg**

□ Yes □ No	**Do you have a cardiac pacemaker?**
Have you ever undergone any of the following examinations?	
□ Yes □ No	Kidney 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)
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
Others: ……..……..…….	
Have you been diagnosed with any of the following diseases?	
□ Yes □ No	HIV
□ Yes □ No	Hepatitis C
□ Yes □ No	Asthma
□ Yes □ No	Allergies requiring treatment
□ Yes □ No	Of the heart
□ Yes □ No	Of the kidneys / adrenal gland
□ Yes □ No	Of the thyroid
□ Yes □ No	Kahler's disease (multiple myeloma)
□ Yes □ No	Diabetes
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 the treating physician.	
For female patients:	
□ Yes □ No	Is there a possibility that you might be pregnant?
□ Yes □ No	Are you currently breastfeeding?

Turn page!

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Name: .....

☐ Yes ☐ No	**Trauma:** when …… what ……..……
☐ Yes ☐ No	**Tumor:** operated on ……..……..
☐ Yes ☐ No	**Therapy:**
	☐ chemo ……..... ☐ immuno …….. ☐ hormone ..……
	☐ radiation ……. ☐ antibody ……..... ☐ other …….....
☐ Yes ☐ No	**Initial examination**
	☐ Therapy since the last examination: ……..……..……..……
	☐ Previous findings available?
	☐ Have previous images been uploaded?
☐ Yes ☐ No	**Have you had kidney or adrenal surgery?**
	☐ cyst……... ☐ dialysis…….. ☐ double kidney.……
	☐ stone……. ☐ kidney failure……. ☐ blood in urine ……
☐ Yes ☐ No	**Heart surgery?**
	☐ Stent ☐ Bypass ☐ Pacemaker
☐ Yes ☐ No	**Have you had thyroid surgery?**
	☐ hashimoto …… ☐ resection …… ☐ partialresection …
	☐ adenom …… ☐ struma …… ☐ euthyrox ……
	☐ thiamazol …… ☐ thyrex ..…… ☐ Others. …….....
☐ Yes ☐ No	**Do you smoke?** How many? ……..… When did you stop? ……..……
☐ Yes ☐ No	Appendectomy / removal of the appendix
☐ Yes ☐ No	Cholecystectomy / removal of the gallbladder
☐ Yes ☐ No	Hysterectomy / removal of the uterus
☐ Yes ☐ No	Oophorectomy / removal of one or both ovaries
☐ Yes ☐ No	Prostatectomy/ removal of the prostate

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

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: .....