DIAGNOSE ZENTRUM BRIGITTENAU

CT

[Patientenname], [Geb.datum]

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 after 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?

Please turn page!

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☐ 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

Please turn page!

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[Patientenname], [Geb.datum]

CT

[redacted]

Heart	
☐ Yes ☐ No	Chestpain
☐ Yes ☐ No	Shortness of breath
☐ Yes ☐ No	Palpitations
☐ Yes ☐ No	High blood pressure
☐ Yes ☐ No	Heart attack
☐ Yes ☐ No	Heart arrhythmias
☐ Yes ☐ No	Heart valva defect
☐ Yes ☐ No	Lipid metabolism disorder
☐ Yes ☐ No	Any other known heart diseases? Specify ……..……..... Any known heart-/ vascular diseases in the family? Who? …….……..... Heart surgery? If yes, specify ……..……..…… Heart implants? If yes, specify ……..……..…… Heart catheter? If yes, specify ……..……..……
Operation	

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:

Uhrzeit	RR	Puls

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: .....