Territory X-Ray Services

T 1300 NT XRAY / 1300 689 729
F (08) 8941 8824
E admin@territoryxray.com.au
W www.territoryxray.com

3/44 Stuart Highway, Stuart Park, NT, 0820

HEALTH HISTORY QUESTIONNAIRE

Name: DOB: M ☐ F ☐

Have had any of the following surgeries **(please tick)**

☐ Caesarian	☐ Cholecystectomy (Gall Bladder)	☐ Prostatectomy
☐ Hysterectomy	☐ Spinal surgery **(please list)**	☐ Thyroidectomy
☐ Tubal Ligation	☐ Bypass	☐ Stent
☐ Oophorectomy (Ovaries removed)	☐ Hernia Repair	☐ Tonsillectomy
☐ Cystoscopy	☐ Testicular surgery	☐ Prolapse surgery
☐ Mastectomy	☐ Appendectomy	☐ Breast Implants
☐ Hip arthroscopy/replacement	☐ Shoulder arthroscopy/replacement	☐ Knee arthroscopy/replacement

Please list any other surgeries you may have had:

_____

Have you had any of the following diagnosed illnesses **(please tick)**

☐ Diabetes	☐ Prostate Disease	☐ Crohn's Disease	☐ Hepatitis
☐ Asthma	☐ Cancer **(please list)**	☐ Anemia	☐ Tuberculosis
☐ Emphysema	☐ Gynecological Disease	☐ Thyroid Disease	☐ Multiple Sclerosis
☐ High Blood pressure	☐ Kidney Disease	☐ Dementia	☐ HIV
☐ Heart Disease **(please list)**	☐ Lung Disease **(please list)**	☐ Reflux	☐ Irritable Bowel
☐ Coeliac	☐ Hearing Loss	☐ Diverticulitis	☐ Eye disease
☐ Epilepsy	☐ Arthritis	☐ Vertigo	☐ Stroke

Please list any other illness you may have:

_____

Are you allergic to any of the following **(please tick)**

☐ Aspirin	☐ Latex	☐ Band aids/tape
☐ Anti-inflammatory	☐ Iodine	☐ Food allergy (Please list)
☐ Antibiotics	☐ Seafood/Shellfish	☐ Hay fever

Please list all allergies to Medication or Food that you may have:

_____

Women only

Date of the first day of your last period:	Are you pregnant: ☐ Y ☐ N
Number of Pregnancies:	Are you breast feeding: ☐ Y ☐ N
Number of Live Births:	Are you experiencing any breast tenderness, lumps or nipple discharge of your breasts? ☐ Y ☐ N

CT Radiographer or Radiologist to complete:

I, _____ have verbally confirmed with the above mentioned patient that there is no chance of pregnancy prior to proceeding with the CT examination. Date: _____

CT Radiographer Signature_____ Patient Signature_____

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IV CONSENT FORM

As part of your procedure today we may be required to inject you with an x-ray dye known as contrast medium. This dye allows us to examine specific parts of your body as requested by your doctor. Although the injection is very safe, it is possible that you'll experience some minor complications. To determine if the dye is appropriate for you, we therefore ask that you answer the following questions accurately and honestly.

1. Have you ever received an injection of contrast medium (x-ray dye)? Yes /No
2. If you have received the injection before, did you experience any side effects? Yes /No
   If yes, please describe what happened: _____
3. Are you allergic to any drugs or food? Yes /No
   If yes, please list them for us: _____

4. **Please circle yes or no if any of the following conditions apply to you by circling the appropriate response:**

Diabetes	Yes / No _____
Asthma	Yes / No _____
Renal (Kidney) Disease	Yes / No _____
Hyperthyroidism	Yes / No _____
Multiple Myeloma (cancer of plasma cells)	Yes / No _____
Liver Failure	Yes / No _____
Sickle Cell (abnormal haemoglobin cell type)	Yes / No _____
Hepatitis	Yes / No _____
HIV	Yes / No _____
Phaeochromocytoma (adrenal gland tumour)	Yes / No _____
Heart Disease	Yes / No _____
Pregnant / Breast Feeding	Yes / No _____

IMPORTANT INFORMATION

There are some side effects and complications that may occur after having an injection of contrast medium.
The **most common side effects** experienced are:

- -A hot flush, particularly in the pelvic region
- -A funny (metallic) taste and/or smell
- -A mild sensation of urination

There are also some **uncommon side effects** which include:

- –Nausea, which passes quickly
- –Vomiting
- –Hives (itchy red spots)
- –Dizziness

In **very rare cases**, more severe reactions have been recorded. These include:

- –Difficulty breathing
- –Shock
- –Convulsions
- –Cardiac and/or respiratory arrest
- –In **extremely** rare cases, a severe reaction can result in death

Should you have any questions or concerns about this information / consent form, please do not hesitate to speak with a member of our staff.
When you are ready, please sign and date where indicated and return this form to reception.

I _____ understand the need for a contrast injection and have been informed of the possible risks and side effects. I agree to receiving the contrast injection if required for my procedure.

PATIENTS SIGNATURE: DATE:_____