Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 (www.wcinyp.com) F: 646-962-0122
Please bring all completed forms to your appointment

(Office use)

Fluoroscopy Questionnaire

Date:_____/_____/_____ Name: _____

Age:_____Height:_____Weight:_____Sex: M ☐ F ☐

For what medical problem are you having this study? _____

How long have you had this problem? _____ Which side? ☐ **Left** ☐ **Right**

Have you had any surgery on the area to be examined? ☐ **Yes** ☐ **No**

If yes, please list surgical procedures and dates:

_____

Do you have an allergy to latex? ☐ **Yes** ☐ **No**

Do you have any allergies to medicines? ☐ **Yes** ☐ **No**

If yes, please list the medications:

_____

Do you have any food allergies? ☐ **Yes** ☐ **No**

If yes, please list what foods you are allergic to:

_____

Your imaging procedure may require the administration of an X-ray dye/contrast (these are two commonly used names for the same thing) which helps the physician interpret your examination.

Have you ever had an injection of X-ray dye/contrast? ☐ **Yes** ☐ **No**

Have you ever had X-ray dye/contrast by mouth, rectum, or other body cavity? ☐ **Yes** ☐ **No**

If YES to any of the above, have you ever experienced the following after receiving an injection of X-ray dye/contrast?

Hives: ☐ **Yes** ☐ **No**

Shortness of breath: ☐ **Yes** ☐ **No**

Fainting/Collapsing: ☐ **Yes** ☐ **No**

FEMALE PATIENTS

Are You Pregnant? ☐ **Yes** ☐ **No**

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X-ray dye/contrast is administered by either an injection through a small needle place into your vein or by mouth, rectum, or body cavity. During the administration of the X-ray dye/contrast you may experience a feeling of warmth, which is normal and expected.

Administration of X-ray dye/contrast is quite safe. However, there is a risk of a reaction. Uncommonly (1 out of 1,000), patients develop sneezing and hives as an adverse reaction to the dye/contrast. Very rarely (1 out of 70,000), death has occurred related to an adverse response to the X-ray dye/contrast.

If you have any questions, please speak to any staff member and they will contact a physician to answer your questions.

I authorize Weill Cornell Imaging at NewYork-Presbyterian, its physicians and other staff to perform the prescribed examination.

Questionnaire Completed By:

_____	_____	_____/_____/20_____
Print First and Last Name	Signature	Date

(FOR OFFICE USE ONLY)
Questionnaire Reviewed By Technologist/ Nurse/ MD:

_____	_____	_____	_____/_____/20_____
Print First and Last Name	Signature	MD/RN/TECH	Date