

**CT SCREENING Cuestionario para Tomografía Computada**

**SPANISH**

Patient Name NOMBRE: \_\_\_\_\_

Today's Date FECHA: \_\_\_\_\_ Age EDAD: \_\_\_\_\_ Weight PESO: \_\_\_\_\_ Height ESTATURA: \_\_\_\_\_ Sex SEXO:  M  F

Yes/Sí		No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If female: is there any possibility you could be pregnant? Si es mujer: ¿hay alguna posibilidad de que pueda estar embarazada?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently breastfeeding? ¿Está amamantando actualmente?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a previous reaction to iodinated contrast media (i.e. CT contrast dye or X-ray dye)? ¿Tuvo una reacción previa a los medios de contraste yodados (Tinta de contraste para TC o tinta para rayos X)? If yes, describe reaction REACCIÓN: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you had a prior reaction to iodinated contrast media, have you been pre-medicated with a corticosteroid (such as prednisone or Solu-Medrol)? Si tuvo una reacción previa a los medios de contraste yodados, ¿ha sido medicado de antemano con un corticosteroide (como prednisona o Solu-Medrol)? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any allergies to food or medication? If yes, please list: _____ ¿Tiene alguna alergia a alimentos o medicamentos? En caso afirmativo, indique: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma? ¿Padece de asma?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, is your asthma currently affecting you? En caso afirmativo, ¿su asma lo está afectando actualmente?
Δ	<input type="checkbox"/>	<input type="checkbox"/>	Do you take Glucophage (metformin)? ¿Toma usted Glucophage (metformina)?
Δ	<input type="checkbox"/>	<input type="checkbox"/>	Do you have kidney disease or kidney failure or kidney transplant? ¿Enfermedad renal, insuficiencia renal o trasplante de riñón?
Δ	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of kidney cancer or mass? ¿Tiene antecedentes de cáncer o masa renal?
Δ	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a family history of kidney failure? ¿Tiene antecedentes familiares de insuficiencia renal?
Δ	<input type="checkbox"/>	<input type="checkbox"/>	Have you previously had kidney surgery? ¿Ha tenido cirugía de riñón anteriormente?
*	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a recent illness or infection in the past week? Type: _____
*	<input type="checkbox"/>	<input type="checkbox"/>	¿Se ha sentido enfermo con náuseas, vómitos o diarrea durante la última semana? Tipo: _____

PLACE PATIENT LABEL HERE

**UW Medicine**

Harborview Medical Center – University of Washington Medical Center  
UW Neighborhood Clinics – Valley Medical Center  
University of Washington Physicians Seattle, Washington

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\_\_\_\_\_  
**Signature of Patient or Legal Guardian**  
**Firma del paciente o tutor legal**

\_\_\_\_\_  
**Printed Name**  
**Imprenta**

\_\_\_\_\_  
**Date**  
**Fecha**

If signed by person other than patient, provide printed name, relationship to patient, description of authority  
Si la firma no es del paciente, indique su nombre, relación y autoridad para firmar.

**THIS SECTION IS FOR STAFF USE ONLY**

\* Serum creatinine within 24 hours

△ Serum creatinine within 2 weeks if "Yes" to answer

Spanish Translation by UWMC Interpreter Services

TECHNOLOGIST SIGNATURE	PRINT NAME	NPI	DATE	TIME
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