CT Screening CT 扫描问卷

Chinese

Patient Name 患者姓名:_____

Today's Date: _____ **Age**: _____ **Weight**: _____ **Height**: _____ **Sex**: ☐ **M** ☐ **F**
今天的日期 年龄： 体重 身高 性别： 男 女

	Yes 有	No 无	
	☐	☐	If female: is there any possibility you could be pregnant? 女性：您有可能怀孕了吗?
	☐	☐	Are you currently breastfeeding? 您目前是否在哺乳？
	☐	☐	Have you had a previous reaction to iodinated contrast media (i.e. CT contrast dye or X-ray dye)? If yes, describe reaction 您过去是否对以碘造影介质（如 CT 造影染料或 X 射线染料）有反应？如是，请描述反应：: _____
	☐	☐	If you had a prior reaction to iodinated contrast media, have you been pre-medicated with a corticosteroid (such as prednisone or Solu-Medrol)? 如您过去对碘造影介质有反应、您是否已预先服用皮质类固醇（例如强的松或 SOLU 甲泼尼龙）？ _____
	☐	☐	Do you have any allergies to food or medication? If yes, please list 您对食物或药物有任何过敏吗？如果有；请列出: _____
	☐	☐	Do you have asthma? 您有哮喘吗？
	☐	☐	If yes, is your asthma currently affecting you? 如有；目前哮喘对您有何影响?
Δ	☐	☐	Do you take Glucophage (metformin)? 您服用格华止（二甲双胍）吗？
Δ	☐	☐	Do you have kidney disease or kidney failure or kidney transplant? 您有肾脏疾或肾功能衰竭或肾移植吗？
Δ	☐	☐	Do you have a history of kidney cancer or mass? 您有肾脏癌或肾肿瘤的病史吗？
Δ	☐	☐	Do you have a family history of kidney failure? 您家族有肾脏癌的病史吗？
Δ	☐	☐	Have you previously had kidney surgery? 您过去做过肾脏的手术吗？
*	☐	☐	Have you had a recent illness or infection in the past week? Type 您过去 一周来有无疾病或感染？如有是那种: _____
*	☐	☐	Have you been feeling sick with nausea, vomiting or diarrhea? 您是否感到恶心、呕吐或腹泻？

PLACE PATIENT LABEL HERE

Signature of Patient or Legal Guardian 病者或法定监护人签名	Printed Name 正楷书写姓名	Date 日期

If signed by person other than patient, provide printed name, relationship to patient, description of authority
如非病者本人签名、请正楷书写姓名、注明与病者关系、说明权限

THIS SECTION IS FOR STAFF USE ONLY 此栏属职员专用

* Serum creatinine within 24 hours Δ **Serum creatinine within 2 weeks if "Yes" to answer**

VASCULAR ACCESS:

DATE _____ **TIME** _____
TECHNOLOGIST / RN _____
IV SITE _____ □ **18g** □ **20g** □ **22g** **ATTEMPTS** _____
□ **OTHER** _____
CREAT / GFR _____
NOTES _____

PLACE PATIENT LABEL HERE