

CONTRAST EXAMINATION

(IVP, CT, ARTHROGRAM, MYELOGRAM, HSG, ALL FLUORO STUDIES)



Date: _____

Name: _____ DOB: _____ Height: _____ Weight: _____

1) Why did your doctor refer you for this examination? (describe your symptoms)

Question:	Yes	No	Comments:
2) Have you ever had a similar exam?	_____	_____	When? _____ Where? _____
3) Is there any chance you might be pregnant?	_____	_____	
4) Have you ever had an x-ray test with an injection? (ex: IVP, CT Heart cath)	_____	_____	If yes, did you have any problems?
5) Do you have any allergies? (ex: food, drug, hayfever)	_____	_____	If yes, what are you allergic to?
6) Do you have any asthma, emphysema, or any other lung problems?	_____	_____	If yes, what?
7) Do you have diabetes?	_____	_____	If yes, do you take insulin or an oral pill/Glucophage?
8) Do you have kidney disease?	_____	_____	
9) Do you have heart trouble?	_____	_____	
10) Have you ever had any cancer?	_____	_____	If yes, of what?
11) List all surgery you have had:			

12) What medicines are you taking? (please use back of sheet if you need to)

13) Any other medical history we should know about?

Patient Signature: _____

Date: _____