



Information received from:  Patient  Nurse  Patient Representative: \_\_\_\_\_

1. Reason for Study: \_\_\_\_\_

2. Past Medical History: \_\_\_\_\_

3. Allergies:  No  Yes - If yes, list: \_\_\_\_\_

4. Previous Adverse Reaction to Contrast Material:  No  Yes - If yes, list: \_\_\_\_\_

5. Previous Surgery:  No  Yes - If yes, list procedure and date: \_\_\_\_\_

6. Lab Values: Total Bili. \_\_\_\_\_ SGOT \_\_\_\_\_ BUN \_\_\_\_\_ Amylase \_\_\_\_\_ Alkaline Phosphate \_\_\_\_\_  
GGT \_\_\_\_\_ CREAT \_\_\_\_\_ Lipase \_\_\_\_\_

7. Patient's Condition:  Cooperative  Uncooperative  Comatose  Confused  Debilitated

8. Currently Pregnant:  No  Yes - If yes, how many weeks: \_\_\_\_\_ Lactating:  No  Yes

**9. Medical History:**

A. Are you currently taking any of the medications listed on the table located on the back of this form?

No  Yes - If yes, what medication? \_\_\_\_\_

B. DIABETIC:  No  Yes - If yes, what medication? \_\_\_\_\_

When was your last dose? \_\_\_\_\_ When is your next dose? \_\_\_\_\_

C. RESPIRATORY PROBLEMS: \_\_\_\_\_ ASTHMA:  No  Yes

D. HEART DISEASE:  CHF  Arrhythmia  Pulmonary HTN  Heart attack (MI)  Chest Pain

E. SICKLE CELL DISEASE  No  Yes PHEOCHROMOCYTOMA  No  Yes

MULTIPLE MYELOMA  No  Yes THYROID DISORDER  No  Yes

F. RENAL DISEASE: Dialysis  No  Yes - If yes, next dialysis appointment is: \_\_\_\_\_

G. Chemo Therapy  No  Yes - If yes, when? \_\_\_\_\_

H. Radiation. Therapy  No  Yes - If yes, when/where? \_\_\_\_\_

10. Contrast Medium:  I.V. Type: \_\_\_\_\_ Amount: \_\_\_\_\_  ORAL: \_\_\_\_\_

11. Patient tolerated first dose to contrast media well:  Yes  No \_\_\_\_\_

Information taken by (Signature/Title): \_\_\_\_\_ Date: \_\_\_\_\_

Any of the above "yes" answers Reviewed by: Radiologist (Print & Sign) \_\_\_\_\_

Pharmacist (Print & Sign): \_\_\_\_\_

For audit use only

