CONTRAST EXAMINATION

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

CNY Diagnostic Imaging Associates

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? _____
3)	Is there any chance you might be pregnant?	____	____	Where?_____
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:_____