

Patient Name:	Date of Study:	
Physician:	DOB:	Age:
<i>General Medical History</i>		
Reason(s) for today's exam: _____ _____		
Do you have a history of cancer? If so, what type(s)? _____ _____		
Do you have any history of surgery in the area being scanned? If so, what and when? _____ _____		
<i>Pregnancy</i>		
Is there any chance that you may be pregnant? If yes, inform the technologist now.	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Date of last menstrual period: _____		
Are you nursing an infant?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, stop nursing for 48 hours after contrast injection.		
<i>Asthma/Allergy History</i>		
Do you have a history of asthma?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, do you use an inhaler every day?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you ever been hospitalized for asthma?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you ever had a severe allergic reaction to anything requiring hospitalization, a breathing tube or epinephrine?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<i>Contrast Allergy History</i>		
Is this the first time you have ever received x-ray contrast medication (x-ray dye) for an exam such as an IVP kidney exam, CT exam or angiogram?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you ever had an allergic reaction to x-ray contrast (x-ray dye)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, what reaction did you have? _____		
<i>Steroid Premedication History</i>		
Have you ever taken or been instructed to take a steroid medication in preparation for an x-ray with contrast (x-ray dye)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, have you taken a steroid medication in preparation for today's exam?	<input type="checkbox"/> YES <input type="checkbox"/> NO	

<i>Kidney Function History</i>	
Do you have diabetes treated with insulin or other medications?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a family history of kidney failure?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a history of "kidney disease" including tumor or transplant?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a history of paraproteinemia, e.g., multiple myeloma?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a history of collagen vascular disease, e.g., scleroderma or lupus?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever had prior kidney surgery?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you take Metformin containing drugs (these are drugs for diabetes, e.g., Glucophage or Glucovance)? If you are unsure, speak with the technologist .	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you take non-steroidal anti-inflammatory (aspirin-like) drugs chronically or at high doses?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you regularly take medications that can cause kidney injury?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you answered yes to any of the above, have you had a renal function test in the last 30 days (serum Creatinine blood tests)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Cardiac History</i>	
Do you have angina or congestive heart failure?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have severe aortic stenosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have primary pulmonary hypertension?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have severe cardiomyopathy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Thyroid History</i>	
Do you have thyroid cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, do you expect to receive radioactive iodine in the next few weeks?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Signature of Patient or Legal Guardian

Date

Patient Name (Print)