

PATIENT HISTORY FOR CONTRAST MEDIA

Patient Name: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

1. Please indicate if you have one of the following \*:

- History of "kidney disease" as an adult or family history of kidney problems
- History of kidney transplant
- Diabetes
- Paraproteinemia syndromes or diseases (e.g. myeloma)
- Collagen vascular disease (e.g. Lupus)
- Recent contrast study (e.g. within the last 7 days)
- Recent surgeries? If yes, please list: \_\_\_\_\_
- Sickle cell disease

Certain medications:

- Metformin or metformin-containing drug combinations (Metformin, Avandamet, Glucophage, Glucophage XR, Glucovance)
- Regular use of nephrotoxic antibiotics, such as aminoglycosides, or non-steroidal anti-inflammatory drugs (e.g. Motrin, Aleve, etc)

**\* If you checked any of the boxes above, please inform your technologist now. You may require special instructions and further blood test(s) to assess your kidney function prior to receiving IV contrast media.**

2. Have you ever had an allergic reaction to IODINE/IV CONTRAST?  YES  NO

If "YES", please describe\*: \_\_\_\_\_

**\*If "YES", based on your reply, you may require pre-medication prior to receiving IV contrast, no IV contrast, or alternative imaging.**

3. Do you have a history of the following medical conditions:

- Asthma (if you have active asthma, bronchospasm, or bronchitis requiring treatment, please inform your technologist **now**)
- Cardiac Disease (angina, congestive heart failure, aortic stenosis, primary pulmonary hypertension, severe but well compensated cardiomyopathy)
- History of allergic (anaphylactic) reaction to one or more allergens

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient, Parent or Guardian)

**\_\_\_\_\_ To be filled out by the technologist performing your exam \_\_\_\_\_**

\_\_\_\_\_ exam performed per protocol \_\_\_\_\_ exam performed per physician / Name: \_\_\_\_\_

Contrast IV – Type/Amt/Rate/Site: \_\_\_\_\_ Contrast Oral – Type/Amt: \_\_\_\_\_

Technologist: \_\_\_\_\_ Date: \_\_\_\_\_

Creatinine: \_\_\_\_\_ Result Date: \_\_\_\_\_ GFR: \_\_\_\_\_

MED REC NO. \_\_\_\_\_  
PATIENT \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
BILLING NO. \_\_\_\_\_

(DRAFT - Rev. 01/07)  
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