PATIENT NAME:_____ DOB: _____

Have you had prior exams relevant to this visit? Where and When?_____

(Females) ARE YOU PREGNANT? Y / N

LMP? _____ HEIGHT_____ WEIGHT_____

DO YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS?

ASTHMA ____ YES ____ NO

HEART DISEASE ____ YES ____NO

LUNG DISEASE ____ YES ___ NO

KIDNEY DISEASE ____ YES ____ NO

KIDNEY REMOVED ____ YES ____NO

HIGH BLOOD PRESSURE ____YES ____NO

MULTIPLE MYELOMA ____ YES ____NO

SWOLLEN ANKLES ____ YES ____ NO

HYSTERECTOMY _____YES ____NO

OVARIES REMOVED ____ YES ____NO

MASTECTOMY _____ YES ____NO

APPENDECTOMY _____ YES ____ NO

LUNG SURGERY _____YES____NO

COLON RESECTION ____YES ____NO

PROSTATE SURGERY ____ YES ____NO

GALLBLADDER REMOVED ____ YES ____NO

HISTORY OF CANCER ____ YES ____ NO IF YES, EXPLAIN: _____

ANY SURGERIES _____YES ____NO IF YES, EXPLAIN: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

IODINE ____YES ___NO

ANY MEDICATION ____ YES ____NO

SEAFOOD __ YES ____NO

STRAWBERRIES ____ YES ____NO

BANANAS ____ YES ___NO

ALLERGY TO IV XRAY CONTRAST ____ YES ____NO

HAVE YOU HAD A PREVIOUS IVP ____ YES ____NO

OR AN ANGIOGRAM ____ YES ____NO

ANY REACTION ____ YES ____NO ____

ARE YOU DIABETIC ____ YES ____NO

DO YOU USE ANY AGENT THAT CONTAINS METFORMIN ____ YES ____ NO

TECHNOLOGIST USE ONLY

WITH / WITHOUT CONTRAST

RADIOLOGIST CALLED Y / N____

_____CC_____

PROTOCOL_____gauge_____

EXAM _____

INFILTRATES ____YES ____NO

PREVIOUS CT EXAM ____YES ____NO

EXISTING IV ____YES ____NO

CREAT _____

CATHETER OUT INTACT ____YES ____NO

EXAM EXPLAINED ____YES ____NO

TECH NOTES_____

POWER INJECTOR USED ___YES ____NO

_____

IV LOCATION _____

_____