CLARKSVILLE IMAGING CENTER

CONTRAST HISTORY FORM

Patient: _____ Age: _____ WT: _____ Xray # _____

Exam: _____ Referring MD: _____

History: _____

Pregnancy: _____ NO _____ YES Contraceptives: _____ NO _____ YES

LMP (date:) _____ Any GYN Surgeries: _____ NO _____ YES

Previous Contrast Reaction: _____ NO _____ YES

Symptoms: Shock Laryngeal edema Hives

Upper Respiratory Rash Other: _____

Treatment: _____

Contrast Allergies: _____ NO _____ YES Name: _____

Asthma: _____ NO _____ YES

CHF (Congestive Heart Failure): _____ NO _____ YES

Sickle Cell Disease: _____ NO _____ YES

Allergic Hives (Urticaria): _____ NO _____ YES

Renal Disease: _____ NO _____ YES

Kidney Tumor or Hx of one kidney: _____ NO _____ YES

Personal Hx of Renal Failure: _____ NO _____ YES

Diabetes: _____ NO _____ YES

Insulin (>2 yrs): _____ NO _____ YES

Insulin Pills (>5 yrs): *Glucophage* _____ NO _____ YES

Hx of Multiple Myeloma: _____ NO _____ YES

Are you taking Glucophage (Metformin): _____ NO _____ YES

Other: _____

Creatinine: _____ Date: _____ BUN: _____ Date: _____

_____ Date: _____

I certify that I have answered the above questionnaire accurately.

Contrast Used: _____ cc's injected: _____