IV CONTRAST HISTORY AND SCREENING FORM

PATIENT NAME: _____ M F DOB: ___/____/____ WEIGHT: _____

HAVE YOU BEEN PRE-MEDICATED FOR THIS EXAM? ◯ YES ◯ NO

HAVE YOU EVER HAD A PREVIOUS ALLERGIC REACTION TO IV X-RAY CONTRAST (DYE)? ◯ YES ◯ NO

If yes, explain: _____

ARE YOU TAKING METFORMIN OR GLUCOPHAGE? ◯ YES ◯ NO BUN _____CREATININE _____

PERSONAL HISTORY:

◯ ASTHMA ◯ DIZZINESS ◯ KIDNEY DISEASE ◯ DIABETES ◯ HEART DISEASE ◯ STROKE ◯ CANCER

◯ BLADDER DISEASE ◯ LIVER DISEASE ◯ SEIZURE DISORDER ◯ HEADACHES ◯ PROSTATE PROBLEMS

IF YES TO ANY OF THE ABOVE QUESTIONS PLEASE EXPLAIN: _____

_____

◯ RENAL DISEASE ◯ HYPERTENSION ◯ HEPATIC DISEASE ◯ ANEMIA/SICKLE CELL _____

◯ HAVE YOU HAD A LIVER TRANSPLANT? Explain _____

◯ INSULIN PUMP/IMPLANTED DRUG INFUSION PUMP_____

◯ INTERNAL ELECTRODES/WIRE STAPLES/ CLIPS/METAL /MESH IMPLANTS/WIRE SUTURES _____

◯ MAGNETIC IMPLANTS/MECHANICAL/ELECTRICAL _____

◯ BODY PIERCING/PATCHES/TATTOO'S/PERMANENT MAKE-UP _____

◯ BREAST TISSUE EXPANDER (IMPLANTED SOFT TISSUE RETRACTORS) _____

◯ DO YOU HAVE PINS IN YOUR HAIR/CLOTHES/HAIR EXTENSIONS/HAIRPIECES/WIG _____

◯ ARE YOU WEARING CLOTHING/ATHLETIC WEAR THAT MAY CONTAIN METALLIC MICROFIBER? _____

I attest the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and consent to contrast agent if needed for proper diagnosis of my procedure. I acknowledge the possibility of side effects with MRI contrast agent and had the opportunity to ask questions related to this form, MRI procedure and understand all information presented to me.

_____ _____ _____

Patient/Parent/Legal Guardian Signature Technologist Signature Date