

# RADIOLOGY ASSOCIATES

## Patient Contrast Check List

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

X-Ray #: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_

**Please answer the following questions carefully**

	Yes	No	Details
Are you allergic to iodine or x-ray dye?			
Have you had a previous <b>IV</b> contrast study: IVP, CT, etc?			
Do you have abnormal kidney function?			
Are you diabetic? If yes, please circle meds: Actos Plus Met, Avandament, Fortamet, Glucophage, Gluophage XR, Glucovance, Metaglip, Metformin Tablets, Metformin XR Tablets, Riomet Oral Solution, Insulin			

Do You Have a History of:	Yes	No	Details
Drug allergies, if yes please list			
Severe asthma			
Please list any surgeries that you have had			
Coronary artery disease or bypass heart surgery			
Myocardial infraction (heart attack, past or present)			
Artial septal defect (a hole in the heart involving the atria)			
Kidney surgery			
Kidney disease			
Are you on dialysis			
Collagen vascular disease such as lupus			
Are you being treated with long term NSAID's If yes, how many per day: _____			
Angina or chest pain			
Pulmonary hypertension			
High blood pressure			
Endocarditis (inflammation of the inside heart lining)			
Cancer disease If yes, have you had surgery, chemotherapy, and/or radiation therapy (Please circle all treatments) and  When did each of the above occur?			
Taken Tylenol or Vitamin C in the past 24 hrs?			

I attest the previous information is correct:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Radiologist Notes -**

**Technologist Notes -**

(Patient Contrast Check List Front Rev 06/06)

