Fluoroscopy History and Screening

Patient name: ______________________ **MRN:** ______________
Patient weight : ______________________

Patient's primary complaint – Why are you here for this exam today? ______________________

☐ Yes ☐ No Do you have a history of Cancer? Where? ______________
Current treatment? ______________
☐ Yes ☐ No Claustrophobic?
☐ Yes ☐ No Driver? NPO x ______________
List medications currently taking ______________

☐ Yes ☐ No Are you pregnant or actively trying to get pregnant?
If yes/no, last menstrual period: ______________
☐ Yes ☐ No Are you breastfeeding?
☐ Yes ☐ No Have you ever had any x-ray dye, iodine or contrast?
Did you have any problems with it? Please explain: ______________
☐ Yes ☐ No Have you had recent blood work drawn?
If yes, where: ______________
☐ Yes ☐ No Have you had a recent chest x-ray?
☐ Yes ☐ No Have you had any other exams related to today's study?
☐ Yes ☐ No Have you had surgery in the area to be scanned?
☐ Yes ☐ No Are you on blood thinners? (baby aspirin, Coumadin, etc.)

Patient Signature: ______________________ **Date:** ______________

FOR OFFICE USE ONLY. PLEASE DO NOT WRITE BELOW THIS LINE.

Current medical symptoms: ______________________

☐ Yes ☐ No Do you have any food or medication allergies?
If yes, please explain: ______________
Any previously diagnosed diseases?______________
Diabetes ☐ Yes ☐ No
If yes, how is it controlled? DIET INSULIN ORAL MED *what type?* ______________

Kidney disease ☐ Yes ☐ No
Sickle Cell disease ☐ Yes ☐ No
Liver disease ☐ Yes ☐ No
Heart disease ☐ Yes ☐ No
Hypertension ☐ Yes ☐ No
Respiratory problems (i.e. asthma, emphysema) ☐ Yes ☐ No
Rheumatoid arthritis or other arthritis ☐ Yes ☐ No

FI time:________min.

PKA _______mGy-m^2

Injection Time: ______________ Gadolinium: ______________ Contrast: ______________

Interviewer Signature: ______________________ **Date:** ______________
Follow-up appointment: ______________________

Rev. 2/2007