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 | Liver disease | Yes |  | No |  |
| Sickle Cell disease | Yes | No | Heart diseaseHypertension | YesYes |  | NoNo | Fl time: min. |

PKA mGy-m2

|  |  |  |
| --- | --- | --- |
| Respiratory problems (i.e. asthma, emphysema) | Yes | No |
| Rheumatoid arthritis or other arthritis | Yes | No |

Injection Time:

Gadolinium:

Contrast:

|  |  |  |  |
| --- | --- | --- | --- |
| **Interviewer Signature:** |  | **Date:** |  |
| **Follow-up appointment:** |  |  |  |