CONTRAST SCREENING FORM

Today's Date: _____

Name: _____ Sex: **M** *or* **F** Weight: _____ Height: _____

Date of Birth: _____

Do you have, or have you ever had any of the following?	**YES**	**NO**
Have you ever had an IV Contrast injection?		
If Yes, did you have a reaction?		
Do you have any history of Renal (Kidney) disease?		
Do you have any history of Hypertension (High Blood Pressure)?		
If yes, is it controlled by medication?		
Do you have any history of Diabetes?		
If yes, are you taking Medication such as Advandament, Glucovance XL, Glupophage, Janumet, Metaglip (Glipizide and Metformin), or Metformin? *IMPORTANT: These medications must not be taken 48 hours after your exam. Please consult your physician.*		
Have you ever had a tumor or been diagnosed with cancer?		
If yes, what type/location/treatment did you have:		
Do you have Sickle Cell Disease?		
Do you have Multiple Myeloma?		
Have you ever had severe hepatic (liver) disease, liver transplant or pending liver transplant?		
FEMALE PATIENTS ONLY:		
Are you pregnant or is there a possibility that you are pregnant?		
Are you currently breastfeeding?		

I attest that the information provided is correct to the best of my knowledge. I have read and understand the contents of this form and I have had the opportunity to ask questions regarding the information on this form. I understand if I provided false information, I am held responsible for any injury or risk that may be involved with this procedure.

X _____ Date: _____

Patient/Parent/Legal Guardian

X _____ Date: _____

Technologist Signature

Notes:

_____

_____

Type of Contrast	**Amount Administered**	**Lot Number**	**Expiration Date**