CONTRAST SCREENING FORM

Today's Date/El dia de hoy: _____

Name/Nombre: _____ Sex: **M** *or* **F** Weight/Peso: _____

Height/Altura: _____ Date of Birth/Fecha de nacimiento: _____

Do you have, or have you ever had any of the following?	**YES**	**NO**
Have you ever had an IV Contrast injection/¿Alguna vez ha recibido una inyección de contraste?		
If Yes, did you have a reaction/en caso afirmativo, ¿tuvo alguna reacción?		
Do you have any history of Renal (Kidney) disease/¿Tiene antecedentes de enfermedad renal?		
Do you have any history of Hypertension (High Blood Pressure)/¿Tiene antecedentes de hipertensión arterial?		
If yes, is it controlled by medication/ En caso afirmativo, ¿se controla con medicamentos?*?*		
Do you have any history of Diabetes/¿Tienes antecedentes de 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.* En caso afirmativo, ¿qué tipo de medicamento toma?		
Have you ever had a tumor or been diagnosed with cancer/¿Te han diagnosticado cáncer?		
If yes, what type/location/treatment did you have/en caso afirmativo, ¿de qué tipo?*:*		
Do you have Sickle Cell Disease/¿enfermedad de célula falciforme?		
Do you have Multiple Myeloma/¿tienes mieloma múltiple?		
Have you ever had severe hepatic (liver) disease, liver transplant or pending liver transplant/¿Tiene problemas de hígado o trasplante?		
FEMALE PATIENTS ONLY/sólo mujeres:		
Are you pregnant or is there a possibility that you are pregnant/¿Estás embarazada?		
Are you currently breastfeeding/¿estas amamantando?**?**		

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.

Acepto que toda la información es correcta. He leído y entiendo la información en este formulario y he tenido la oportunidad de hacer cualquier pregunta. Entiendo que si he proporcionado información falsa, soy responsable de cualquier lesión o riesgo.

X _____ Date/Fecha: _____

Patient/Parent/Legal Guardian

Firma del paciente

X _____ Date: _____

Technologist Signature

Notes: _____

Type of Contrast	Amount Administered	Lot Number	Expiration Date

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