CNY DIAGNOSTIC IMAGING
a Rezolut partner

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CONTRAST EXAMINATION

(IVP, CT, ARTHROGRAM, HSG, ALL FLUORO STUDIES)

Date: _____ / _____ / _____ Name:

Date of Birth: Height: Weight:

Why did your doctor refer you for this examination? (describe your symptoms)

_____

_____

Question	Yes	No	Comments
1. Have you ever had a similar exam?	❑	❑	When? _____ Where? _____
2. Is there any chance you might be pregnant?	❑	❑	
3. Have you ever had an x-ray test with an injection?(ex: IVP, CT Heart cath)	❑	❑	If yes, did you have any problems? _____
4. Do you have any allergies? (ex: food, drug, hay fever)	❑	❑	If yes, what are you allergic to? _____ _____
5. Do you have any asthma, emphysema, or any other lung problems?	❑	❑	If yes, what? _____
6. Do you smoke?	❑	❑	If yes, how many packs per day? _____ How many years have you smoked? _____
7. Are you a former smoker?	❑	❑	Quit date: _____ How many years did you smoke? _____ How many packs per day did you smoke? _____
8. Do you have diabetes?	❑	❑	If yes, do you take insulin or an oral pill/ Glucophage? _____
9. Do you have kidney disease?	❑	❑	
10. Do you have heart trouble?	❑	❑	
11. Have you ever had any cancer?	❑	❑	If yes, of what? _____
12. List all surgery you have had:	❑	❑	

_____

_____

13. What medicines are you taking? (please use back of sheet if you need to) _____

_____

14. Any other medical history we should know about? _____

_____

Patient Signature

_____ / _____ / _____
Date

REV 6/2023