REGIONAL MEDICAL IMAGING

IVP HISTORY FORM

DATE: _____ REFERRING PHYSICIAN: _____

PATIENT: _____ AGE: _____ WEIGHT: _____

REASON FOR EXAM/COMPLAINTS: _____

_____

_____

DO YOU SEE A KIDNEY SPECIALIST (DOCTOR) FOR YOUR PROBLEMS? ☐ YES ☐ NO

IF YES, WHO DO YOU SEE? _____

DO YOU HAVE ANY KNOWN KIDNEY DISEASE? ☐ YES ☐ NO

DO YOU OR YOUR DOCTOR SUSPECT KIDNEY STONES? ☐ YES ☐ NO

CLINICAL HISTORY

YES	NO		YES	NO	
☐	☐	RECENT LAB/BLOOD WORK	☐	☐	**RENAL FAILURE**
☐	☐	PACEMAKER AND ANEURYSM CLIPS	☐	☐	**MULTIPLE MYELOMA**
☐	☐	CARDIAC/CORONARY ART. STENTS	☐	☐	**PHEOCHROMOCYTOMA**
☐	☐	**DIABETIC**	☐	☐	**SICKLE CELL ANEMIA**
☐	☐	GLUCOPHAGE	☐	☐	IRREGULAR HEART BEAT
☐	☐	GLUCOVANCE	☐	☐	**ANY CHANCE YOU ARE PREGNANT NOW**
☐	☐	METFORMIN	☐	☐	HIGH BLOOD PRESSURE
☐	☐	AVANDAMET	☐	☐	LUPUS
☐	☐	ACTOPLUSMET	☐	☐	**PREVIOUS CONTRAST REACTION TO IODINE**
☐	☐	FORTAMET	☐	☐	SMOKER (QUIT _____,
☐	☐	ASTHMA			PACK/DAY _____, NUMBER OF YEARS _____)
☐	☐	CHF	☐	☐	HISTORY OF CANCER
					RAD. THERAPY _____, CHEMO _____

ALLERGIES _____

MEDICATIONS _____

SURGERIES _____

_____

PREVIOUS CT, X-RAYS (INCLUDING IVP), MRI's, PET SCAN, AND WHERE? _____

_____

**** PLEASE READ AND SIGN - CONSENT FOR CONTRAST - ON BACK ****

NOTES: _____

* YOUR BLADDER NEEDS TO BE EMPTY BEFORE THIS EXAMINATION. PLEASE USE THE RESTROOM PRIOR TO EXAM.

CONTRAST CONSENT:

I understand that the use of contrast material is not without risk and may cause undesirable side effects, such as injury to a nerve, artery or vein and tissue damage at the injection site and/or adjacent areas. Occasionally, allergic reactions, chills or hives and/or heart or blood pressure problems can occur. Very rarely (approximately one case in 40,000) a life-threatening reaction could occur. The physicians and staff of Regional Medical Imaging, P.C. are well trained to treat these reactions.

I understand that in the case of pregnant patients, permanent impairment of the unborn fetus has been associated with the use of contrast material. I certify to the best of my knowledge that I am not pregnant.

I have read or have had read to me the contrast consent portion of the IVP History Form. I have had the opportunity to ask questions and had these questions answered.

Patient Signature:_____ Date: _____

(or legal guardian/durable power of attorney for healthcare if patient is unable to sign or is a non-emancipated minor)

TECH COMMENTS

Contrast _____

Vol. _____

TECH _____