Regional Medical Imaging
IVP Patient History Form

Clinical Details: Staff use only		
BUN:	Contrast:	# Views:
Creat:	Used:	
eGFR:	Bottle Size:	Tech Initials:

Patient History

Today's Date: **Referring Physician:**

Patient Name: **DOB:** **Weight:** **Height:**

If Patient is a minor or nursing home patient-Name of accompanying adult and relationship to patient:

Order States:

Patient States:

Surgical History & Date(s)

Personal History of Cancer & Date(s)

Treatment Type (Chemo/Radiation)& Date(s)

Previous X-Ray, CT, MRI, or US study?

Smoking History-Lung Screening			
☐ None Provided	☐ Current	Packs per day:	Number of years smoked:
☐ Never	☐ Past	Quit - How long ago?	History of Lung cancer?

PLEASE CONTINUE ON THE NEXT PAGE

Please indicate if you have any of the following:					
Yes	No		Yes	No	
☐	☐	**Recent Lab/Blood Work** **Where?**	☐	☐	**Asthma** **Inhaler/Medication:**
☐	☐	**Chance of Pregnancy** **Last Menstrual Period:**	☐	☐	**Breastfeeding** **If yes: recommend 24 hour discard**
☐	☐	**Pacemaker or Aneurysm Clips**	☐	☐	**Renal failure**
☐	☐	**Cardiac/Coronary Art. Stents**	☐	☐	**High Blood Pressure**
☐	☐	**Diabetes**	**What type of Diabetes Medication?**		
☐	☐	**Previous Contrast Reaction**	**What type of reaction?**		

Medications: _____

_____

_____

_____

Allergies: _____

Clinical Information:					
Yes	No		Yes	No	
☐	☐	**Congestive Heart Failure**	☐	☐	**Irregular Heart Beat**
☐	☐	**Pheochromocytoma**	☐	☐	**Sickle Cell Anemia**
☐	☐	**Multiple Myeloma**	☐	☐	**Lupus**

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)

Technologist comments:

_____

_____

_____