PATIENT HISTORY FORM FOR FLUORO AND CONTRAST STUDIES

* **Please Fill In Any Necessary Blanks or Circle No/Yes**

Section 1	**Patient Name:**	**Date:**

List Known Allergies:	**Procedure:**
Have you ever had this exam before? NO YES If Yes specify when and where:	Have you ever been diagnosed with cancer? NO YES If yes, what type?_______________________________ When were you diagnosed?______________________ What type of treatment have you had?______________

Circle No/Yes to the following questions:

Is there any possibility you might be pregnant?	NO	YES
Have you had anything to eat or drink since midnight?	NO	YES
Did you follow the preparation instructions given to you for the exam?	NO	YES
Have you experienced any trouble swallowing?	NO	YES
Have you experienced any nausea or vomiting?	NO	YES
Have you experienced any diarrhea or constipation?	NO	YES
Have you experienced any rectal bleeding?	NO	YES
Have you ever been diagnosed with an ulcer?	NO	YES
Have you ever had surgery on your esophagus or abdomen?	NO	YES
Have you been experiencing any abdomen pain?	NO	YES
Have you been experiencing any chest pain?	NO	YES
Are you a diabetic?	NO	YES

Please provide any necessary explanations to the questions above:

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Patient Signature____ Date________________________

WellStar Health System
☐Cobb ☐Douglas ☐Kennestone
☐Paulding ☐Windy Hill

PATIENT IDENTIFICATION STICKER

Patient History form for Fluoro and Contrast Studies

To Be Filled In By The Technologist

Section 2	Pre-Assessment

Do you have any major health problems:

[] High Blood Pressure [] Heart Disease
[] Kidneys [] Lungs
[] Angina
[] Other, Please specify: ______________________________

Have you experienced a previous Reaction to Contrast?
NO YES

If Yes, Nature of Reaction:________________________
____

Do you take Glucophage, Glucovance, Metaglip or any generics?
NO YES

Creatinine:	**BUN:**	**GFR:**
Date Performed:	**Date Performed:**	**Date Performed:**

Contrast used:
[] Omnipaque 180 [] Omnipaque 300

[] Cysto conray [] Other:_______________

Injection Site:
[] Existing IV [] Porta Cath

[] INT [] Other:______________________

Quantity:
[] 100 ml [] 50 ml

[] Other:_________________________________

Injected by:

Injection Time:

Section 3	Post-Assessment

Was there a Contrast Reaction with this exam:
[] NO []YES

If Yes, Type of reaction:
[] Hives [] N/V
[] Sneezing [] Other

Was there an Extravasation: [] No [] Yes

List medications given:

[] None
[] Benadryl ____________mg
[] Epinephrine __________mg
[] Solu-Medrol __________mg
[] Other:________________

The physician notified of contrast reaction / extravasation:

Incident report completed: [] NO [] YES
- Forward form to Risk management

Pharmacy notified: [] NO [] YES
- Complete Drug reaction form and send to pharmacy

Completed by: ____(Technologist)

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