



CONTRAST MEDIA INFORMATION

PATIENT NAME:

AGE:

EXAM ORDERED:

YES NO

HAVE YOU HAD A PREVIOUS IMAGING STUDY THAT REQUIRED AN INJECTION OF CONTRAST MEDIA (DYE)?

IF YES, DID YOU EXPERIENCE ANY DIFFICULTIES FROM THE CONTRAST INJECTION?

DO YOU HAVE ANY OF THE FOLLOWING?

YES NO

ASTHMA/ HAYFEVER

HEART DISEASE OR HEART PROBLEMS

CONGESTIVE HEART FAILURE

RESPIRATORY FAILURE

HIGH BLOOD PRESSURE

RENAL (KIDNEY) DISEASE

YES NO

RENAL (KIDNEY) FAILURE

SICKLE CELL DISEASE

DIABETIC

STROKE

DO YOU TAKE GLUCOPHAGE?

DO YOU TAKE BLOOD THINNERS?

PLEASE LIST ALL ALLERGIES : _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

PLEASE LIST ANY SURGERIES: _____

PATIENT

SIGNATURE _____ DATE _____