

Name:	
MRN:	DOB:
Referring Physician	n:
Date of Service:	
* :	

Circle One) Have you had a previous imaging study that required an injection of contrast (dye)? Yes No If YES (did you experience any difficulties from the contrast? No If YES to any of the above, please describe: Patient Weight DO YOU HAVE ANY OF THE FOLLOWING? Asthma / Hay fever Yes No If YES, do you use an inhaler? Yes No How often? Diabetes Yes No If YES, do you take Glucophage or Metformin? Yes No Smoker / Smoking History Yes No High Cholesterol Yes No Heart Attack Yes No Congestive Heart Failure Yes No Congestive Heart Failure Yes No Angina (Severe Chest Pain) Yes No Stroke Yes No Family History of Heart Disease Yes No Family History of Heart Disease Yes No Pacemaker / Defibrillation Yes No Sickle Cell Disease Failure Yes No Kidney Disease or Failure Yes No No No Kidney Disease or Failure Yes No N							
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f YES, did you experience any difficulties from the contrast? Are you allergic to lodine, Shellfish or Seafood? Pattern Weight DO YOU HAVE ANY OF THE FOLLOWING? Asthma / Hay fever Diabetes Pattern Yes No If YES, do you use an inhaler? Past No If YES, do you use an inhaler? Pressure / Hay fever Diabetes Yes No If YES, do you use an inhaler? Pressure / Hay fever Diabetes Yes No If YES, do you take Glucophage or Metformin? Pressure / Hay fever Diabetes No Smoker / Smoking History Yes No If YES, do you take Glucophage or Metformin? Pressure / Hay fever No Heart Disease Yes No Congestive Heart Failure Yes No Congestive Heart Failure Yes No Rangina (Severe Chest Pain) Yes No Pacemaker / Defibrillation Yes No Pacemaker / Defibrillation Yes No Respiratory Disease or Failure Yes No Kidney Yes No Kidney Yes No Kidney Yes N	Have you had a provious imaging stud	v that ro	auired a	un injection of contrast (dve)?	Vae	•	
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Consent Signed: Yes No