Imaging Specialists

Contrast History Form

Patient Name:_____ Date: _____

Are you pregnant? Yes or No Last menstrual cycle ____/____/____

1. **Trauma:** ☐ Y / ☐ N **Where?** _____
2. History/Diagnosis: Why was the exam ordered? _____

   _____

   _____
3. Allergies/Asthma/Anaphylactic reaction? ☐ Y / ☐ N _____

   _____
4. Previous Reaction to CT/X-ray Dye (contrast): ☐ Y / ☐ N _____
5. Prior Surgeries: (Check all that apply): ☐ **NONE**

   ☐AAA ☐Brain ☐Lung ☐Heart ☐Breast ☐Cervical ☐Lumbar
   ☐Carotid ☐Tubal ☐Hernia ☐Bladder ☐Sinus ☐Hysterectomy
   ☐Kidney ☐Prostate ☐Small Bowel ☐Large Bowel ☐Tonsillectomy
   ☐Appendectomy ☐Gallbladder ☐Pacemaker ☐Defibrillator ☐Bariatric Surgery
   ☐ Other: _____
6. History of Cancer? ☐Y / ☐ N Type? _____
7. Have you had Chemotherapy? ☐ Y / ☐N Radiation? ☐ Y / ☐ N
8. Smoking status: ☐ Current smoker ☐ Former smoker ☐ Never smoker
9. Kidney Problems? ☐ Y / ☐ N _____Requiring Dialysis? ☐ Y / ☐ N _____
10. Diabetes? ☐ Y / ☐ N ☐ oral medication ☐ insulin

Technologist section

Creatinine: _____ GFR: _____ Contrast type: **Omnipaque 350** Route: **IV** Amount: _____ml

TECH PERFORMING EXAM:_____ Date:_____