



MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Last 4 numbers of SS#: _____

Referring Physician: _____ Height: _____ Weight: _____

Reason for Exam: _____

How long have you had this problem? _____ Are you seeing your physician in the next 24 hours? Yes No

Medical history (check all that apply) Diabetes High blood pressure Smoking Kidney disease/failure Asthma
 COPD Dialysis Multiple myeloma Adrenal Gland Tumor Heart Disease Lung Disease

Have you been treated for cancer?: Never Currently Previously Treatment completed

Cancer type: _____ Approximate date of cancer diagnosis: _____

List any major surgeries: _____

Prior studies

Have you had previous related imaging studies done? Yes No What part(s) of your body? _____

Where did you get these exams done? _____ What year? _____

Type of exam: X-Ray CT MRI Ultrasound Nuclear Medicine PETCT

Pregnancy Disclosure (section required for all female patients between the ages of 10 and 55)

Initial:

_____ **No, I am not** pregnant at the time of this x-ray examination / _____ **Yes, I am** pregnant at this time

_____ I realize that x-rays/radiation may be harmful to my unborn child; however, I wish to continue with today's exam.

Have you had tubal ligation or partial/full hysterectomy? Yes No Date of last menstrual period (LMP): _____

Iodine contrast history (only for patients having contrast exams)

Have you ever had previous imaging that required injection of contrast media/dye? Yes No

Have you ever had an allergic reaction to IV Contrast used in any imaging procedure (CT, MRI, X-Ray)? Yes No

Are you taking Glucophage? Glucovance? (Metformin) Yes No

Are you taking Avandament, Actoplusmet, Fortemet, Kombiglyze, Prandimet, Riomet, Glumetza, or Janumet? Yes No

Patient Signature: _____ **Date:** _____

Baptist M&S Staff Full Signature: _____ **Date:** _____

----- SECTION BELOW ONLY FOR TECHNOLOGIST AND BAPTIST M&S PERSONNEL -----

Patient Fasting? Yes No Enteric Contrast: Rectal / Oral Type: _____ Contrast Type Injected: _____

Volume _____ ml. Lot#: _____ Exp. Date: _____ IV Access: Time: _____ Location: _____

Catheter Size/Type: _____ Number of Attempts: _____ IV Started By: _____ Injected By: _____

Allergy problems post contrast? Yes No Date Lab Drawn: _____ Creatinine within normal limits: Yes No NA

If no, Creatinine Level: _____ B.U.N. Level: _____ Notes: _____

Baptist M&S Staff Full Signature: _____ **Date:** _____