

Austin Radiological Association Patient History/Contrast Form

Name _____ Date of Birth _____ Date _____
 When will you visit your doctor again? _____ Weight _____ Height _____ Age _____
 Signs and Symptoms _____
 Is this an injury? Yes No If yes, date of injury _____ Symptoms are worse on: Right Left

HAVE YOU HAD ANY PREVIOUS IMAGING STUDIES OF THE BODY PART BEING EXAMINED TODAY?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	MRI/CT scan	If Yes, done at: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone scan	If Yes, done at: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ultrasound	If Yes, done at: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Angiogram	If Yes, done at: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Plain x-rays	If Yes, done at: _____

HAVE YOU EVER HAD?

Yes No Previous imaging that required an injection of contrast media/dye?
 If yes, did you have a reaction or experience any difficulties due to any imaging contrast/dye injection? Yes No
 (If Yes, please explain) _____

Yes No Surgery to the part of your body being examined today? If yes, explain: _____

Yes No Surgery to any other part of your body? If yes, explain: _____

Yes No Cancer or other tumor? If yes, explain: _____

Yes No Radiation therapy or chemotherapy? If yes, explain: _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

<input type="checkbox"/> Yes <input type="checkbox"/> No Angina pectoris (severe constricting chest pain)	<input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Myeloma
<input type="checkbox"/> Yes <input type="checkbox"/> No Aortic valve disorders (mitral valve prolapse)	<input type="checkbox"/> Yes <input type="checkbox"/> No Myocardial infarction (heart attack)
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No Pheochromocytoma
<input type="checkbox"/> Yes <input type="checkbox"/> No Atrial fibrillation of the heart	<input type="checkbox"/> Yes <input type="checkbox"/> No Primary pulmonary HTN (not High Blood Pressure)
<input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac dysrhythmia (irregular heart beat)	<input type="checkbox"/> Yes <input type="checkbox"/> No Renal (kidney failure)
<input type="checkbox"/> Yes <input type="checkbox"/> No Chronic kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Severe debilitation (describe) _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Sickle cell disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease/problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Smoking history (# of years) _____
<input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Tachycardia (abnormally high heart rhythm rate)
<input type="checkbox"/> Yes <input type="checkbox"/> No Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Unstable angina
<input type="checkbox"/> Yes <input type="checkbox"/> No Liver transplant/pending transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking Glucophage? Glucovance? (Metformin) _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Lung disease	
<input type="checkbox"/> Yes <input type="checkbox"/> No Lupus	

Please list below all medications you are currently taking and all of your allergies (medicine, food or other):
 Medications: _____
 Allergies: _____

I (we) understand that there may be a possibility I will need an injection and/or oral dose of contrast to complete my diagnostic exam. I (we) also understand there is a possibility that I may have an allergic reaction to the contrast and/or an extravasation of contrast into the surrounding tissues of where my intravenous catheter is placed. Both can be minor to severe. **Reactions** may include, but are not limited to: nausea, vomiting, warm sensation, altered taste, itching, hives, rash, headache, pallor, nasal stuffiness, dizziness, chills, swelling around the face and eyes, anxiety, tachycardia, hypertension, hypotension, shortness of breath, wheezing, laryngospasm, bronchospasm, anaphylaxis, convulsions, cardiopulmonary arrest and death. **Extravasations** (leakage into tissue) may be minor with small amounts of contrast, but can be severe if tissues react to the contrast. Large volume extravasations may possibly lead to surgical intervention.

I (we) have read and understand the above information and give consent for the administration of intravenous contrast and/or oral contrast as indicated.

Patient Signature: _____ Date: _____

TO BE COMPLETED BY TECHNOLOGIST/ARA PERSONNEL ONLY

Was patient pre-medicated for contrast allergy? Yes No BP _____ Patient fasting? Yes No
 IV access: Time _____ Location: _____ Catheter size _____ Number of attempts _____
 Contrast injected _____ Volume _____ ml Rate _____ (ml/sec) Lot # _____ Exp Date _____ Time _____ AM/PM
 Allergy problems post contrast? Yes No If yes, complete Contrast Incident Form
 IV DC'd w/catheter intact? Yes No Creatinine level: _____ Date _____ GFR _____
 Comments _____

ARA Staff Full Signature _____



Austin Radiological Association

THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT.



WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

- Yes No Are you pregnant
- Yes No Ever had metal removed from eye
- Yes No Worked with metal fragments, ie. welding, grinding, etc.
- Yes No Pacemaker
- Yes No Aneurysm clip(s)
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Magnet therapy patch
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis/implant (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Foil based medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, or metallic structures
- Yes No Joint replacement (hip, knee, etc)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm, or pessary
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
- Yes No *(Remove before entering MR system room)*
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Halo vest or metallic cervical fixation device
- Yes No Attached weights of any kind (wrist, ankle, or body)

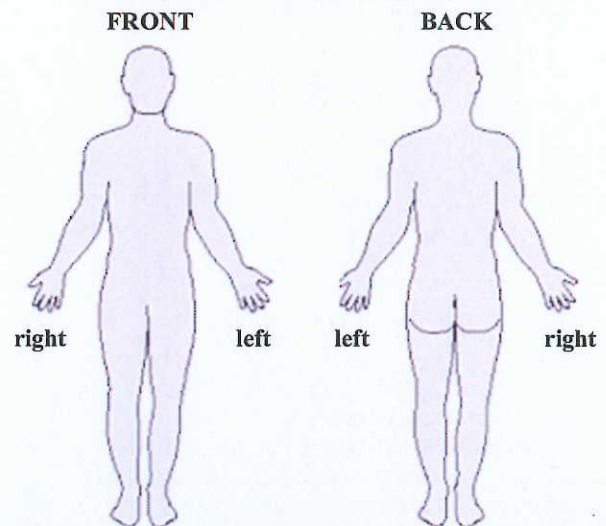


IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system, you will be asked to change into a gown and remove your shoes. You must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hairpins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clippers, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR room.

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's Signature _____

Date _____

Front Desk staff signature _____

Date _____

RN, RT, EMT-P signature _____

Date _____