

# 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 ( <b>not High Blood Pressure</b> )
<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)

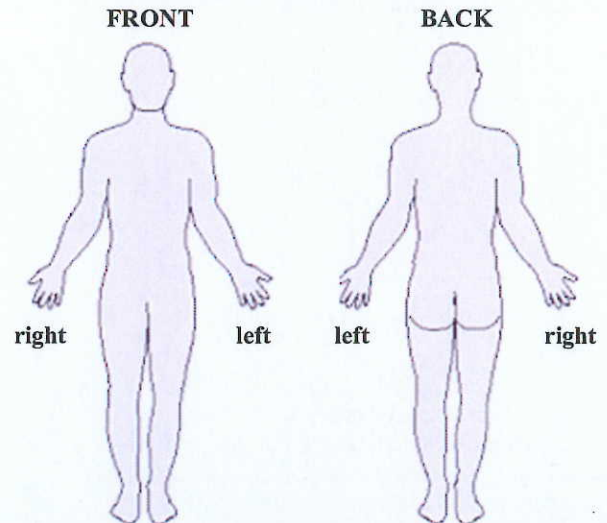


## IMPORTANT INSTRUCTIONS

**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 \_\_\_\_\_