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?

☐ Yes ☐ No	MRI/CT scan	If Yes, done at:	_____
☐ Yes ☐ No	Bone scan	If Yes, done at:	_____
☐ Yes ☐ No	Ultrasound	If Yes, done at:	_____
☐ Yes ☐ No	Angiogram	If Yes, done at:	_____
☐ Yes ☐ 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?

☐ Yes ☐ No	Aortic valve disorders (mitral valve prolapse)	☐ Yes ☐ No	Lupus
☐ Yes ☐ No	Irregular heartbeat (fibrillation or dysrhythmia)	☐ Yes ☐ No	Multiple Myeloma
☐ Yes ☐ No	Heart Problems If yes, explain: _____	☐ Yes ☐ No	Pheochromocytoma
☐ Yes ☐ No	Chronic kidney disease If yes, explain: _____	☐ Yes ☐ No	Primary pulmonary HTN (Not high blood pressure)
☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Severe debilitation Describe: _____
☐ Yes ☐ No	Lung disease If yes, explain: _____	☐ Yes ☐ No	Smoking History Quit x _____ years
☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Sickle cell disease _____ #cigs/day x _____ years
☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Are you taking Glucophage or Glucovance? (Metformin)

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, anaphlaxis, 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/Guardian Signature: _____ **Date:** _____

TO BE COMPLETED BY TECHNOLOGIST/ARA PERSONNEL ONLY

IV Access: Location: _____ Cath size: _____ # of Attempts: _____ Employee Initial-Starting IV: _____

IV Administration: Volume _____ ml Rate _____ ml/sec Exp. Date _____ Contrast Type & Lot # _____

Employee Initial-Administering Contrast: _____ Time: _____ Employee Initial-Removing IV: _____

Patient observed for 15 minutes post contrast injection:
Patient discharged without complaints, or symptoms of adverse event? Yes No Employee Initial-Discharged By: _____

Complete a Contrast Incident Form for any adverse event; note any allergic reactions in Medication History in MI.

Notes: _____

Report Name: PTCONTRASTFORM