



AUSTIN RADIOLOGICAL ASSOCIATION PATIENT HISTORY/CONTRAST FORM

Name _____ Date of Birth _____ Height _____ Age _____
When will you visit your doctor again? _____ Weight _____

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?			
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(If Yes, please explain)</i> _____			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Surgery to the part of your body being examined today?	If yes, explain _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Surgery to any other part of your body?	If yes, explain _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer or other tumor?	If yes, explain _____
<input type="checkbox"/> Yes	<input type="checkbox"/> 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	Aortic valve disorders (mitral valve prolapse)	<input type="checkbox"/> Yes <input type="checkbox"/> No Lupus
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular heartbeat (fibrillation or dysrhythmia)	<input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Myeloma
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Problems If yes, explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Pheochromocytoma
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic kidney disease If yes, explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Primary pulmonary HTN (Not high blood pressure)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Severe debilitation Describe: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lung disease If yes, explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Smoking History Quit x _____ years
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Sickle cell disease _____ #cigs/day x _____ years
<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> 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, 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/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY ARA PERSONNEL ONLY

Notes: _____

