X-ray History Form

AdventHealth

PATIENT HISTORY FORM FOR: (check one)

☐ Arthrogram ☐ Cystogram ☐ IVP ☐ Port Check Dye Study

TO BE COMPLETED BY THE PATIENT:

If this exam is related to an injury, how did it occur? ______________________________

If this exam is related to pain, where is the pain located? ______________________________

List any surgeries related to your area of pain ______________________________

What is your current weight? ____________

YES	NO	
☐	☐	Do you have a history of cancer? What type: ______________________________
☐	☐	Did you have ☐ Chemotherapy ☐ Radiation If yes, specify date of last treatment: _____________
		For female patients only:
☐	☐	Are you pregnant or possibly pregnant? If Yes, how many weeks? _______________
☐	☐	Are you currently nursing? If Yes, discontinue for 24 hours after the procedure
		For patients receiving IV contrast:
☐	☐	1. Do you have multiple myeloma, adrenal tumor (pheochromocytoma), myasthenia gravis (gMG) or auto immune disease?
☐	☐	2. Do you have sickle cell anemia or are you in sickle cell crisis?
☐	☐	3. Are you diabetic?
☐	☐	3b. If yes to # 3, do you take Metformin, Glumetza, Fortamet, Riomet, Glucophage or Glucophage XR?
☐	☐	4. Are you on dialysis?
☐	☐	5. Do you have renal impairment?
☐	☐	6. Do you have one kidney or had a kidney transplant?
☐	☐	7. Are you allergic to Iodine or Imaging contrast? If yes, date occurred: ____________
		If yes to # 7, describe the reaction that occurred: ______________________________
☐	☐	7b. If yes to # 7, were you pre-medicated prior to the exam?

______________________	______________________	______________________	_________/_________	
Patient/Authorized Person Signature	Printed Name	Title (Self,Spouse,Nurse,etc.)	Date	Time

______________________	______________________	_________/_________	
Interpreter Signature	OPID	Date	Time

X-ray History Form (continued)

FLORIDA HOSPITAL
The skill to heal. The spirit to care.®

For staff use, for patients having IVP's

☐ Yes ☐ No Has the patient received IV contrast within the last 24 hours? If yes, Contact radiologist. **GFR:** ___________ **Creatinine:** _______________

Date/Time of labs: _____________________

- Inpatient/ED- All patients age 18 and over; Labs (GFR) within 7 days.
- Outpatient - All patients age 60 and older; Labs (GFR) within 45 days.
- If answer "Yes" to question(s) #1-6. GFR required.
    - If GFR greater than 46, give contrast & follow appropriate GFR pathway below. If GFR 45 or less, contact radiologist.
- If answer "Yes" to question #7 & 7b. Refer to Premedication Protocol.

GFR, Glomerular Filtration Rate, is an estimate of kidney function.

Pathway A:	46- 60 GFR.	Pre & Post procedure hydrations are recommended. No need to contact radiologist.
Pathway B:	30- 45 GFR.	Pre & Post procedure hydrations are required. Contact radiologist.
Pathway C:	0- 29 GFR.	Contact radiologist.

______________________________ ______________________________ ______________/____________

Technologist Authentication OPID Date Time

Patient Label or

Patient Name ____

DOB ________________________ MRN _________________________