



PATIENT INFORMATION

Date _____

Special Needs _____

Diagnosis or symptoms _____

Are you allergic to x-ray contrast? Yes No Not sure Never had x-ray contrast

List medication allergies _____

Any possibility of pregnancy Yes No Date of last menstrual cycle _____

Comments: _____

Medical History:

No Major Medical Problems _____

Hypertension Yes No

Asthma Yes No

Multiple Myeloma Yes No

Diabetes Yes No

Heart Disease Yes No

Kidney problems/stones Yes No

Stroke Yes No

Other _____

Surgical History:

None _____

Gall Bladder Yes No

Appendix Yes No

Uterus/Ovaries Yes No

Intestines Yes No

Other _____

Cancer History:

None _____

Breast left/right Yes No

Lung left/right Yes No

Prostate Yes No

Colon Yes No

Other _____

I have been informed on my exam/procedure and all of my questions have been answered.

Patient Signature

Rectal contrast enhances the lower colon which provides the Radiologist with the necessary information for proper diagnosis. **Failure to use rectal contrast when needed may result in an incomplete or inaccurate diagnosis.**

Do you consent to rectal contrast? Yes No If no, please sign _____

TECHNICAL NOTES:

IV contrast (name/amount) _____ Oral contrast (name/amount) _____

IV Site _____ BUN _____ Creatinine _____

Technologist's Signature _____



**IMAGING SERVICES
HISTORY ASSESSMENT**

Patient Identification