UROLOGY
SAN ANTONIO

Imaging Center
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IMAGING HISTORY
REV. 11/12/2015

Patient Name _____ Account No. _____

Today's Date_____ Gender: Male / Female D.O.B. _____ Weight_____

Medical History

1. Have you had previous imaging, CTs or X-rays? If yes, what medical facility did the testing?	Yes	No
2. Have you had previous surgery? If yes, what type?	Yes	No
3. Do you have a personal history of hypertension?	Yes	No
4. Do you have a personal history of hives or hay fever?	Yes	No
5. Do you have a personal history of diabetes?	Yes	No
5A. Are you currently taking the drug *Metformin* or *Glucophage*?	Yes	No
6. Do you have a personal history of multiple myeloma or amyloidosis?	Yes	No
7. Have you had cancer of any type?	Yes	No
8. Have you ever had any kidney problems or procedures? If yes, describe	Yes	No
8A. Do you have a solitary kidney or a renal transplant?	Yes	No
9. Are you taking nephrotoxic or chemotherapy drugs (e.g. *Gentamycin*, *Tobramycin*, *Amphotericin*)?	Yes	No
10. Have you had acute trauma (shock) or unstable blood pressure?	Yes	No
11. Do you have a seizure disorder, brain tumor or have had a stroke?	Yes	No

Female Patients

1. Are you pregnant or think there is a possibility that you may be pregnant? If yes, please discuss with the technologist before your exam.	Yes	No
2. What was the first day of last menstrual cycle?		

Patients Scheduled for CT with IV Contrast

1. Have you ever had an imaging/X-ray study with intravenous contrast (e.g.: IVP, CT, angiography, etc.)	Yes	No
1A. If yes, did you have a reaction to the contrast media used? Describe the reaction	Yes	No
1B. Was treatment needed?	Yes	No
2. Do you have any allergies to medications? If yes, what medications?	Yes	No
3. Do you have any allergies to foods (e.g.: shellfish, shrimp)? If yes, what foods?	Yes	No
4. Do you have asthma?	Yes	No
5. Do you have sickle cell anemia?	Yes	No
6. Have you had a heart attack in the last 8 weeks? If yes, circle the type: myocardial infarction, unstable angina, angina pectoris, valvular heart disease, cardic dysrhythmia, other:	Yes	No
7. If the patient cannot communicate his or her medical history, has a severe general debility or is at increased risk of aspiration, circle Yes.	Yes	

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Referred By_____ Diagnosis _____	☐ Abdomen ☐ Pelvis ☐ Chest ☐ Other