

**DEPARTMENT OF
MEDICAL IMAGING
Pre-Contrast Checklist**

Dear Patient: Welcome to Medical Imaging. Please answer **all** of the following questions, **1-10**. This information will assist us in learning about your medical history. The Technologist who will perform your study can assist you with any questions or concerns you have with this form.

Patient Name: _____ Age: _____

1. Reason you are having this exam? _____
2. For female patients:
Any possibility that you may be pregnant? YES NO Are you breast feeding? YES NO
3. Have you had any barium or contrast exams within the past week? YES NO
If YES, please notify the receptionist or technologist immediately.
4. Do you have any allergies to medications? YES NO
If YES, please explain: _____
5. Do you take any medications? YES NO
If YES, please list: _____

6. Have you ever had an injection for an x-ray exam, specifically contrast/dye? YES NO
7. Do you have any of the following?
 Thyroid disease? High blood pressure? Heart disease? Asthma?
 Diabetes?
Do you take Glucophage, Glucovance, Avandamet, Metaglip, Metformin, Janumet, Avandaryl, Actoplusmet or Fortamet? YES NO
 Kidney disease? History of multiple myeloma? History of pheochromocytoma?
8. Do you have any other known diseases? YES NO
If YES, please explain: _____
9. Have you had surgery before? YES NO
If YES, please explain: _____
10. Did you take the preparation for your exam? YES NO N/A

Prior scans and x-rays are often helpful as we interpret your current exam.

Have you had any CT Scans, MRI, X-Rays or Other Imaging Studies in the Past?

What type? _____ When? _____ Where? _____

DEPARTMENT USE ONLY

CONTRAST GIVEN? YES NO OMNIPAQUE Volume _____ VISIPAQUE Volume _____
BARIUM CONTRAST GIVEN? YES NO Volume: _____

CONTACT YOUR DOCTOR IF YOU HAVE ANY QUESTIONS ABOUT YOUR MEDICATIONS

Metformin information given? YES NO Any changes in Medications? YES NO
Post Instructions Given? Rad Dose: _____

Name: _____ Date: _____

Technologist Name: _____

