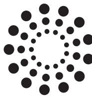
SAFETY FORM

Patient History and Contrast Sheet



CHEYENNE RADIOLOGY

Name: ______________________________ Birthdate: ______________

Age: __________ Sex: __________ Weight: ____________ Height: ______________

Next Doctors Appointment: ______________________________

Do you have X-rays/CT/MRI/other studies relating to this exam? ______________________

Symptoms you are having: ______________________________

____

Cancer ☐ Yes ☐ No

Type of Cancer: ____________________

Diagnosed when? ____________________

Hypertension ☐ Yes ☐ No

Shortness of Breath ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Are you on glucophage/metformin? ☐ Yes ☐ No

Blood Thinning/Aspirin Therapy ☐ Yes ☐ No

Sickle Cell ☐ Yes ☐ No

Kidney Problems ☐ Yes ☐ No

If so, describe ____________________

____

Heart Condition ☐ Yes ☐ No

If so, describe ____________________

____

List medication you are taking: ______________________________

____

List allergies: ______________________________

List allergic reactions you have had: ______________________________

Any previous surgery on the part being examined today? ☐ Yes ☐ No

If yes, what type of surgery? ______________________________

Female patients, any chance of pregnancy? ☐ Yes ☐ No Are you breast feeding? ☐ Yes ☐ No

An injection of contrast is required to obtain your study. This contrast is quite safe, however, as with all medications there is a slight risk of allergic reaction.

I have answered the above questions and all information is correct to the best of my knowledge.

Patient's Signature: ______________________________ **Date:** ______________

Technologist's Signature: ______________________________