Patient Name_____Date_____

1. Have you ever had an iodine contrast injection for any test? Yes_____ No_____
   Did you have any reaction to the injection? Yes_____ No_____
   If so, what was the reaction? _____

2. Do you have any allergies?_____

3. Do you have asthma or any other lung conditions now or as a child? Yes_____ No_____

4. Do you have any history of kidney problems? Yes_____ No_____
   If so, please explain_____

5. Do you have any history of heart disease? Yes _____ No _____

6. Have you ever been diagnosed with cancer? Yes _____ No_____ When _____
   If so, which part of the body?_____ What treatment have you had?_____

7. Are you diabetic? Yes____ No____ If so, are you taking GLUCOPHAGE, METFORMIN, GLUCOVANCE, GLYBURIDE, GLIPIZIDE, FORTAMET, ACTOPLUS, JENUVIA, JANUMET, ONGLYZA, KOMBIGLYZE OR ANY OTHER ORAL DIABETIC MEDICATION?

8. Are you currently taking medication? Yes _____ No _____
   If so, what medication and when was it taken last? _____

9. Did you eat or drink anything in the last three hours? Yes_____ No_____

10. Have you had any surgical procedures? Yes_____ No _____
    If so, please explain_____

11. Have you had any prior imaging (CAT SCAN, MRI, ULTRASOUND ETC...) for this problem? Yes_____ No_____
    If so, where was it done_____

12. What symptoms caused you to seek medical attention?_____
    _____

IS THERE ANY POSSIBILITY THAT YOU ARE PREGNANT YES_____ NO_____