CATHOLIC HEALTH INITIATIVES®

Saint Clare's Hospital

IVP QUESTIONNAIRE

PATIENT NAME:_____ DATE OF BIRTH:_____

HOME PHONE:_____ WORK PHONE:_____

WHAT SYMPTOMS HAVE YOU HAD:_____

_____

NAME OF PHYSICIAN ORDER THIS TEST:_____

HAVE YOU EVER HAD A REACTION TO DYE OR CONTRAST? ❑ YES ❑ NO

IF YES, WHAT TYPE OF REACTION_____

LIST ANY ALLERGIES TO FOOD AND/OR MEDICATION:_____

_____

ARE YOU PREGNANT? ❑ YES ❑ NO DATE OF LAST MENSTRUAL PERIOD_____

DO YOU TAKE GLUCOPHAGE OR GLUCOVANCE? ❑ YES ❑ NO

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

❑ DIABETES ❑ HEART DISEASE ❑ HAY FEVER

❑ GOUT ❑ HIGH BLOOD PRESSURE ❑ KIDNEY DISEASE

❑ ASTHMA ❑ SICKLE CELL ANEMIA

PLEASE LIST ANY MEDICATION YOU TAKE:_____

_____

SIGNATURE:_____ DATE:_____

OFFICE USE ONLY

IS THE PATIENT'S JACKET CHART OR REQUISITION PRESENT? ❑ YES ❑ NO

BUN _____ CREATININE _____ APPROVED BY:_____

TIME:_____ CONTRAST:_____

AMOUNT:_____ SIGNATURE:_____