# SAINT CLARE'S HOSPITAL

**PATIENT LABEL**

## RADIOLOGY DEPARTMENT
## MEDICAL / MEDICATION HISTORY

Physician Name:_____ Date of last physical:_____

Are you under the care of a physician? ❑ Yes ❑ No If yes, for what condition(s)?_____

Past medical history:_____

**Patient Denies Allergies: ❑ Yes ❑ No**

**ALLERGIES / RADIOLOGY / ANESTHESIA**

| Medication/Food/Herbal Allergies | Reaction / Side Effects |
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| Allergy to Latex:*Institute Latex Allergy Protocol | ❑ Yes | ❑ No | Are you pregnant? | ❑ Yes | ❑ No |
| Reaction to Anesthesia | ❑ Yes | ❑ No | Breastfeeding | ❑ Yes | ❑ No |
| Family history of reaction to anesthesia | ❑ Yes | ❑ No | Artificial Valves or Joints | ❑ Yes | ❑ No |
| Reaction to medical / dental treatment | ❑ Yes | ❑ No | History of Rheumatic Fever | ❑ Yes | ❑ No |

**Height: _____ Weight: _____ lb / kg** ❑ Estimated

## MEDICATIONS TAKEN AT HOME PRIOR TO THIS PROCEDURE

**Include: prescriptions, over-the-counters, patches, inhalers, eye drops, birth control, vitamins & herbals**

**Information Source:** ❑ Patient ❑ Spouse ❑ Wallet Card ❑ MAR from other facility ❑ Pharmacy/Drugstore ❑ Brought meds from home ❑ Other_____

❑ On No medications at home

❑ Unable to Obtain Medication History – REASON must be explained:_____

| Date | Drug Name | Dose | Route | Freq | Last Taken Date/Time |
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RN / Tech Signature:_____ Date:_____ Time:_____

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RN / Tech Signature:_____ Date:_____ Time:_____