CATHOLIC HEALTH INITIATIVES®

Saint Clare's Hospital

MYELOGRAM QUESTIONNAIRE

PATIENT NAME:_____ DATE OF BIRTH:_____

HOME PHONE:_____ WORK PHONE:_____

HAVE YOU EVER HAD A MYELOGRAM BEFORE? ❑ YES ❑ NO

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
❑ EPILEPSY	❑ THYROID DISORDER	❑ KIDNEY DISEASE
❑ MULTIPLE MYELOMA	❑ SICKLE CELL ANEMIA	❑ DEPRESSION
❑ ALCOHOLISM	❑ ATTENTION DEFICIT	❑ HYPERACTIVITY DISORDER

PLEASE LIST ANY MEDICATION YOU TAKE:_____

_____

SIGNATURE:_____ DATE:_____