INJECTION HISTORY SHEET

❑ Brick ❑ CMCH ❑ EHT ❑Festival ❑Galloway ❑ Somers Point ❑ Wall Twp.

Name_____ Date_____ Age_____

LMP_____Weight _____ Exam_____Referring Physician_____

Why are you having today's exam?_____

_____

_____

Have you had any recent **prior** CT, MRI, Ultrasound CT/PET, NM or endoscopy exams? ❑Yes ❑No
If so, where and when:_____

Prior surgical and medical history:_____

_____

List all medications:_____

Level of Pain (1 – 10):_____

Have you ever had x-ray dye? ❑Yes ❑No _____ Reaction? ❑Yes ❑No _____

Are you pre-medicated with Prednisone/ Benadryl for today's exam? ❑Yes ❑No

IMPORTANT: If you are allergic to iodine (x-ray dye), please notify the technologist.

Smoking History	❑No	❑Yes	
History of allergies	❑No	❑Yes	Describe _____
Diabetes	❑No	❑Yes	**Do you take the following:** (please circle)
Kidney Problems	❑No	❑Yes	
Heart Problems	❑No	❑Yes	
Lung Problems	❑No	❑Yes	
Hypertension	❑No	❑Yes	
Multiple Myeloma	❑No	❑Yes	
Sickle Cell Anemia	❑No	❑Yes	
Breast Feeding	❑No	❑Yes	
Cancer	❑No	❑Yes	
Chemotherapy	❑No	❑Yes	Finished? ❑No ❑Yes When_____ Where_____
Radiation	❑No	❑Yes	Have you had treatment since your last CT Scan? ❑No ❑Yes
Myasthenia Gravis	❑No	❑Yes	If yes, what type of treatment_____

Glucophage **Metformin** **Riomet**
Glucophage XL **Glucovance**
Metaglip **Fortamet**
Janumet **Avandamet**
Actoplus-met **Glumetza**

The above medications must be stopped for 48 hours AFTER this exam.

Patient/Parent/Guardian Signature_____

- **Technologist Notes** -

NON CONTRAST REASON_____

Most Recent Labs: BUN _____ Creatinine _____ as of _____ ❑None available

CURRENT INJECTION: _____ cc OPTIRAY 300/320 OMNIPAQUE 180/300
ISOVUE 370 VISIPAQUE 320
Lot # _____ Expiration Date_____

Injected by:_____ Site:_____ Angiocath :_____g

Reaction: ❑No ❑Yes Description _____

Dr. _____ was on the premises at the time of injection.