ABERCROMBIE RADIOLOGICAL CONSULTANTS, INC.
MEDICAL HISTORY
Please Print

Date _____

Name _____ D.O.B _____ Weight _____lbs.

What problems are you having that this test is to help answer? _____

_____

_____

_____

Any previous CT scan, Ultrasound, MRI, Nuclear Medicine exams, X-ray's or Barium studies? (Circle)
If yes, where? when?_____

Have you ever had x-ray contrast dye? (Kidney dye or CT dye) YES NO
If yes, did you have a reaction? YES NO
What kind of reaction? _____

Have you ever had MRI contrast dye? YES NO
If yes, did you have a reaction? YES NO
What kind of reaction? _____

Do you smoke? YES NO

Former smoker: When did you quit? _____ How many years did you smoke? _____

Do you have asthma, hay fever or ***allergies*** (**including medication allergies**)? YES NO
If yes, please list _____

MEDICAL HISTORY:

Check if you have any of the following:

❑ Lung Problems ❑ Liver Disease/Cirrhosis ❑ Anemia ❑ Previous Head Injury
❑ Multiple Myeloma ❑ Fatigue/Weakness ❑ Seizures ❑ Metal Slivers in Eyes
❑ Heart Problems ❑ High Blood Pressure ❑ Renal Disease ❑ Other_____
❑ Explain Heart Problems: _____
❑ Diabetes – If yes, are you taking Glucophage or Metformin? YES NO DO NOT KNOW
If yes, has your doctor asked you to stop taking it for this test? YES NO
❑ Cancer? (List types) _____
Chemotherapy YES NO Date of last chemo _____
Radiation Therapy YES NO Date of last radiation _____

Please list all SURGERIES*:* Date:

_____ _____
_____ _____
_____ _____

Are you taking any medications? YES NO
If yes, please list _____

FOR FEMALE PATIENTS: What is the date of your last menstrual period? _____/_____/_____
Is there a possibility you could be pregnant? YES NO
Are you currently breastfeeding? YES NO

EXAM NOTES: _____

Contrast/Medication	Amount used	Lot #/Exp.
Omnipaque 300	ml	
Omniscan	ml	

Number of Images:

Flouro Time:

Contrast/Medication	Amount Used	Lot #/ Exp.
Lidocaine 1%	ml	
	ml	
Xanax	mg	

Technologist: **Radiologist:**

Revised: 5/2021