Center for Diagnostic Imaging
Fluoroscopy History Form
IVP – BE -UGI

Name____________________________________________ Date_________________________________

Physician’s Name_____________________________________________________________________

1. Why did you go to the doctor?______________________________________________________

2. Did you ever have this test before? Yes or No
   If yes, Where? ____________________________When?________________________________

3. What time did you last eat or drink anything?

   CHECK YES OR NO FOR THE FOLLOWING:

   YES   NO

   Do you have any medical problems?
   Heart       ____ _____________
   Lung       ____ _____________
   Abdomen      ____ _____________
   Kidney       ____ _____________
   Prostate       ____ _____________
   Gynecological       ____ _____________

   Do you have any allergies?
   Are you allergic to iodine?       ____ _____________
   Are you allergic to shellfish?       ____ _____________

   Have you ever had any surgery?
   If yes, what type and when? ________________________________________________________

   Do you have diabetes?       ____ _____________
   Do you take glucophage?       ____ _____________
   Have you experienced weight loss?       ____ _____________
   Blood in stool?       ____ _____________
   Blood in urine?       ____ _____________
   Vomiting?       ____ _____________
   Diarrhea?       ____ _____________
   Kidney stones?
   If yes, Left or Right

   What influenced you to choose our facility for your Radiology needs?
   Doctor referral □   Advertising □   Friend or Family □   Other □ _____________

   Patient Signature_________________________________________ Date__________________