DIAGNOSTIC HEALTH ALASKA

Alaska's Home for Medical Imaging Since 1984

General History, Screening & Consent Form

Name: _____**Sex**: M F **Birth Date**: _____ **Age**: _____

Height: _____**Weight**:_____**Physician**:_____

Procedure(s): _____
Reason you are having this exam today? (Please explain in detail):

Have you had any previous exams related to this problem? Yes No

If yes please explain: _____

List previous surgeries: _____

List current Medications: _____

_____

Females only:
Are you pregnant? Y N N/A **Last menstrual period**:_____

List any drug, food, or latex allergies: _____
*** Are you taking Metformin Hydrochloride (Glucophage, Glucovance, Avandemet, Metaglip, Fortamet)?** Yes No
*** Have you ever had a previous allergic reaction to x-ray contrast (dye)?** Yes No
If yes, explain: _____

Any personal history of:

- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Allergic Respiratory Disease
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Are you breast feeding at this time?
- ☐ Yes ☐ No History of falls in the last 30 days
- ☐ Yes ☐ No Kidney Disease/Kidney Failure
- ☐ Yes ☐ No Are you on Dialysis?
- ☐ Yes ☐ No Bladder Disease
- ☐ Yes ☐ No Cancer
- ☐ Yes ☐ No Heart Disease
- ☐ Yes ☐ No Prostate Problems
- ☐ Yes ☐ No Seizure Disorder
- ☐ Yes ☐ No Multiple Myeloma
- ☐ Yes ☐ No Blood disorder/Sickle cell
- ☐ Yes ☐ No Recent diarrhea in past 2-3 days?

Any other medical problems, infections, or concerns? _____

***Acknowledgement*: I have answered these questions to the best of my knowledge and understand the information presented to me. I give consent to perform the procedure(s) listed above.**

_____ _____
Patient/Parent/Guardian Signature **Date**

_____ _____
Technologist Signature **Date**