CONTRAST CONSENT FORM

HAVE YOU EVER HAD AN X-RAY OR CT SCAN DYE INJECTION				☐ YES	☐ NO
HAVE YOU EVER HAD AN MRI SCAN DYE INJECTION				☐ YES	☐ NO
Did you have any complications with any of the above injections				☐ YES	☐ NO
If yes, please explain					
DO YOU HAVE A HISTORY OF SENSITIVITY TO IODINE				☐ YES	☐ NO
DO YOU HAVE ANY ALLERGIES TO MEDICATION				☐ YES	☐ NO
If yes, please explain					
HAVE YOU EVER HAD AN ANAPHYLACTIC REACTION OR AN ALLERGIC REACTION THAT REQUIRED MEDICAL ATTENTION (Anaphylactic reaction is an allergic reaction with difficulty breathing, closing of the throat, or swelling of the mouth or throat)				☐ YES	☐ NO
If yes, please explain					
DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING					
Heart Problems	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
Lung Problems	☐ YES	☐ NO	Asthma	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO	Sickle Cell Disease	☐ YES	☐ NO
Kidney Failure	☐ YES	☐ NO	Multiple Myeloma	☐ YES	☐ NO
If yes, please explain treatment					
ARE YOU TAKING ANY BLOOD THINNERS					
If yes, please explain					
ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING					
Glucophage	☐ YES	☐ NO	Metaglip	☐ YES	☐ NO
Avandamet	☐ YES	☐ NO	Glucovance	☐ YES	☐ NO
Metformin	☐ YES	☐ NO			
FEMALES ONLY	ANY POSSIBILITY OF PREGNANCY			☐ YES	☐ NO
FEMALES ONLY	ARE YOU CURRENTLY BREASTFEEDING			☐ YES	☐ NO

The above information is correct to the best of my knowledge.

Patient Signature _____