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? ____

	YES	NO
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