

IVP HISTORY SHEET

Name: _____ DOB: _____ Date: _____

Referring Physician: _____ Are you Pregnant? (Y/N) _____

1. WHY DID YOUR DOCTOR ORDER THIS EXAM? _____

2. DO YOU HAVE: (Y/N If yes, Explain)

A. Blood in Urine _____ _____

B. Back pain _____ Location? _____

C. Abdomen Pain _____ Location? _____

D. High Blood Pressure _____ _____

E. Heart Disease _____ _____

F. Urinate Frequently _____ How frequently? _____

G. Asthma _____ _____

H. Hay Fever _____ _____

I. Allergies _____ _____

Allergic to: _____ Reaction: _____

▪ Contrast _____

▪ Medication _____

J. Diabetes _____ Are you on Glucophage? _____

K. Kidney Stones _____ _____

L. Kidney Disease _____ _____

3. HAVE YOU EVER HAD ABDOMINAL SURGERY?

Type _____ Year _____

Type _____ Year _____

4. HAVE YOU EVER HAD AN IVP? _____ If yes, what type and when? _____

Results, if known _____

5. ARE YOU TAKING ANY MEDICATION? _____

For Technologist Use Only:

Contrast Type and Amount _____

Contrast Reaction: No _____ Yes _____ What type? _____

Technologist's Initials _____ If ISOVUE was used, why? _____