



IVP QUESTIONNAIRE

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Pre-Medicated: Y N (Circle)

Your Symptoms: \_\_\_\_\_

Please answer the following questions:

Yes No (Circle) Have you ever had an IVP before? If yes, when and where:

Yes No (Circle) Have you had abdominal surgery? If yes, please list:

Yes No (Circle) Do you have abdominal pain? Please specify: \_\_\_\_\_

Yes No (Circle) Do you have ANY allergies to ANYTHING that induced shortness of breath, hives/rash, swelling of your tongue or lips? Please list: \_\_\_\_\_

(Circle the answers to the following):

- Yes No Reaction to IV Dye?
Yes No Asthma/Hay Fever?
Yes No Heart Trouble?
Yes No Insulin Diabetes?
Yes No Fever?
Yes No Painful Urination?
Yes No History of Cancer?
Yes No Do you eat shellfish?
Yes No History of Kidney Stones?
Yes No Hypertension?
Yes No Taking Glucophage?
Yes No Blood in Urine?
Yes No Multiple Myeloma?
Yes No Sickle Cell Disease?
Yes No History of Tumors?
Yes No Pregnant?

(Office Use Only)

Technologist \_\_\_\_\_ Amt. Contrast \_\_\_\_\_

Type of Contrast \_\_\_\_\_ Injection Site \_\_\_\_\_

Reaction Noted/Symptoms \_\_\_\_\_