Reston Radiology Consultants

IVP HISTORY SHEET

Name:_______________________ DOB: ___________ Date:__________

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

1. WHY DID YOUR DOCTOR ORDER THIS EXAM? _________________________

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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? _________________________________

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For Technologist Use Only:
Contrast Type and Amount ____
Contrast Reaction: No _____ Yes _____ What type? _____________________
Technologist's Initials ________ If ISOVUE was used, why? __________________