

cystogram screening form

Patient name _____ Date _____ Age _____

Ordering physician _____

Please complete the following confidential questions and give to the technologist before your examinations. Your answers will aid the Radiologist, an M.D. who is a specialist in x-ray work, and your own Doctor, to make a more accurate diagnosis.

type

- Cystogram Stress cystogram Voiding cystourethrogram

What is your chief complaint or reason for having this x-ray? _____

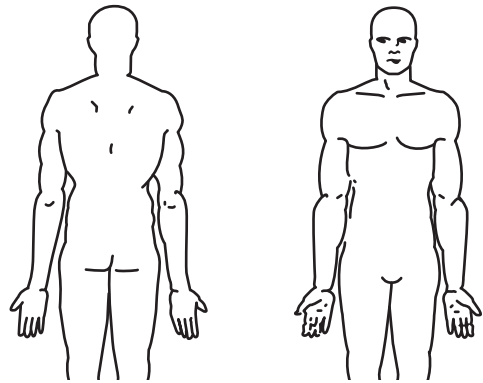
symptoms

Please indicate if you have any of the following symptoms.

- Pain or discomfort (please indicate location on diagram)
 Right Left Back Front
- Burning or pain on urination
 Frequent urination
 Difficulty in urination
 Blood in urine
 Bladder infection
 High blood pressure
 Previous kidney stone

BACK

FRONT



- Have you ever had this type of exam before? Yes No
 If so, when _____ Where _____
- Previous surgery? Yes No
 If so, when _____ Where _____

allergies

Please indicate if you have the following.

- | | | | |
|--|--|-----------------------|--|
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medications | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food | <input type="checkbox"/> Yes <input type="checkbox"/> No | In particular seafood | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had an allergic reaction to anything? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Do you have asthma? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Renal problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Female patients only

Date of last menstrual period _____

Note: Please notify the Technologist if you are pregnant, or if there is a possibility that you may be.

Patient signature _____ Date _____