

IVP screening form

Name _____ Date _____ Date of birth _____

MRN# _____ Who is your ordering physician? _____

*Please complete the following confidential questionnaire and return to the receptionist before your examination.
Your answers will aid the Radiologist and your Doctor in making an accurate diagnosis.*

What is your chief complaint or reason for having this exam? _____

Any previous IVP/IVP Nephrogram Exams Yes No (please describe below)

Date _____ Where _____

Findings _____

Any previous surgery Yes No (please describe below)

What kind? _____

Date _____ Where _____

Please indicate if you have any of the following conditions.

High blood pressure

Allergy to Penicillin

Malnutrition

Low blood pressure

(if yes, what kind of reaction)

Asthma

Angina

Palpitations

Irregular heartbeat

Allergy to other meds

Congestive heart failure

Heart attack

(if yes, what) _____

Pulmonary hypertension

Renal (kidney) problems

Sickle cell

Diabetes (if yes, are you

Allergies other

Senility

on Glucophage or Metformin?)

(if yes, what) _____

Allergy to X-Ray dye

Women only

Are you pregnant? Yes No

Date of last period _____

Patient signature _____ Date _____

BUN _____

Creat. _____

GFR _____

Result date _____