INTRANAVENOUS CONTRAST SCREENING FORM

Your healthcare provider has ordered an exam that may require intravenous contrast material ("xray dye"). Please respond to the following questions as accurately as possible:

1. Have you ever had a previous problem with IV contrast?  
   YES  NO
   If yes, please give details:__________________________________________

2. Have you ever had a life-threatening allergic reaction?  
   YES  NO
   If yes, please give details:__________________________________________

3. Do you have diabetes?  
   YES  NO

4. Do you take any METFORMIN-containing medications?  
   YES  NO
   (Glucophage, Fortamet, Metaglip, Avandamet, Glucovance, Glumetza, Riomet)

5. Are you on medication for high blood pressure?  
   YES  NO

6. Do you have a history of kidney disease or a single kidney?  
   YES  NO

7. Have you ever had kidney surgery?  
   YES  NO

8. Have you ever been on dialysis?  
   YES  NO

9. Have you ever had an organ transplant?  
   YES  NO

10. Do you have a history of multiple myeloma (bone cancer)?  
    YES  NO

11. Have you ever been told you have protein in your urine (proteinuria)?  
    YES  NO

Patient Signature____________________________________________________________Date_________

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If YES to any question 3 through 11, a current Cr/GFR is suggested (within 90 days).

Cr/GFR_______________________________Date of Labs:__________Please obtain copy of lab report.

If YES to question 1, premedication is recommended for previous mild or moderate allergic reaction. IV contrast should be avoided if there is history of prior severe allergic contrast reaction.