736 Battlefield Blvd N, Chesapeake, VA 23320

1QUEST

RADIOLOGY CONTRAST QUESTIONNAIRE

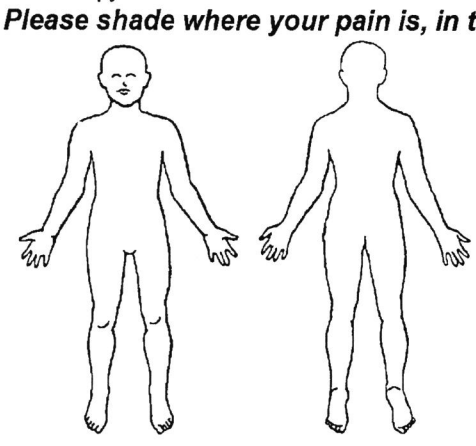
PATIENT'S NAME: _____ DOB: _____ DATE: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

1. Describe your problem and how long you have had it. _____
2. Is this a result of an injury? ❑YES ❑ NO If yes, describe. _____
3. Have you had surgery for this problem? ❑ YES ❑ NO If yes, when and what type? _____
4. Please list all previous surgeries: _____
5. Have you had any other tests for this problem? ❑ YES ❑ NO
6. If yes, please tell us what, when, where and the results: ❑ Myelogram ❑ CT Scan ❑ MRI Scan ❑ X-Ray
7. Do you have any history of cancer? ❑ YES ❑ NO If yes, where in you body? _____
8. Do you have any history of tumors? ❑ YES ❑ NO If yes, where in you body? _____
9. How has it been treated? __ Surgery __ Radiation Therapy __ Chemotherapy

If you are having a CT or MRI scan of your SPINE Please shade where your pain is, in this drawing.

INDICATE YOUR SYMPTOMS	RIGHT	LEFT
Neck Pain		
Arm Pain		
Arm Numb		
Arm Weak		
Leg Pain		
Leg Numb		
Leg Weak		
Bowel Dysfunction		
Bladder Dysfunction		



Pertinent Allergies Past History Record		YES - Explain
Is there a chance you could be pregnant. ❑ YES ❑ NO **LMP**_____		
Have you ever been given IV X-ray contrast (for exams such as CT scan, Cardiac Catherization, or Kidney x-rays – if yes did you have any reactions, please explain	❑ YES ❑ NO	
Do you have Asthma/Hay Fever?	❑ YES ❑ NO	
Are you allergic to Foods/Medication?	❑ YES ❑ NO	
Do you have any history of High Blood Pressure or Heart Disease? Are you currently taking medication?	❑ YES ❑ NO	
Do you have breathing problems? Like Emphysema or COPD?	❑ YES ❑ NO	
♦ Do you have Lupus/Myeloma?	❑ YES ❑ NO	
♦ Do you have Sickle Cell Disease?	❑ YES ❑ NO	
Do you have Kidney problems such as infections, stones, renal insufficiency or dialysis?	❑ YES ❑ NO	
Are you Diabetic? If YES, please answer the next question.	❑ YES ❑ NO	
Are you currently taking the oral diabetes medicine containing Metformin?	❑ YES ❑ NO	

♦ (Technologist must consult the Radiologist prior to any contrast administration)

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT'S SIGNATURE _____ (Parent signature if patient is a minor)

ACCT#

DOB ACCT

CHESAPEAKE REGIONAL
MEDICAL CENTER

1MEDREC

Outpatient Medication Reconciliation Form

Patient Name _____ **Date/Time** _____

(A) **This form is for informational purposes only and NOT to be used as a Physician Order. It is NOT to be used for inpatient admissions.**
(B) **This is NOT a prescription. It is a list of your medications and new orders.**
(C) **If you have any questions regarding any medications listed on this form, or about any medications you may have been on before coming to the hospital, please call your Primary Physician.**
(D) **If your physician needs another copy of this list, please have him/her call Health Information Services at: 757-312-6114.**

Part A

Do Not Use: **U, QD, qd, MS, MSO4, MgSO4, D, Leading Decimal (.X mg), Trailing Zero (X.0 mg), IU, QOD, µg**

Medication Name	Time of last dose	Continue	Discontinue

Part B

Information collected by: _____

- ☐ Copy given to patient
- ☐ Patient/Caregiver Signature:_____
- ☐ Next provider of care: Dr._____
- ☐ Copy faxed to CRMC Health Information Services at 312-6644.
- ☐ Copy hand delivered to CRMC Health Information Services at 312-6644.

New Prescriptions Ordered and Given to Patient

Nurse:_____ **Date/Time:**_____

White-Medical Record Yellow-Patient

ACCT#
DOB
ACCT
PT
MR#