

## HEALTH HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M  F

Have had any of the following surgeries (**please tick**)

<input type="checkbox"/> Caesarian	<input type="checkbox"/> Cholecystectomy (Gall Bladder)	<input type="checkbox"/> Prostatectomy
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Spinal surgery ( <b>please list</b> )	<input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Bypass	<input type="checkbox"/> Stent
<input type="checkbox"/> Oophorectomy (Ovaries removed)	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Cystoscopy	<input type="checkbox"/> Testicular surgery	<input type="checkbox"/> Prolapse surgery
<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Breast Implants
<input type="checkbox"/> Hip arthroscopy/replacement	<input type="checkbox"/> Shoulder arthroscopy/replacement	<input type="checkbox"/> Knee arthroscopy/replacement

Please list any other surgeries you may have had,

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Have you had any of the following diagnosed illnesses (**please tick**)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Prostate Disease	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer ( <b>please list</b> )	<input type="checkbox"/> Anemia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Gynecological Disease	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Dementia	<input type="checkbox"/> HIV
<input type="checkbox"/> Heart Disease ( <b>please list</b> )	<input type="checkbox"/> Lung Disease ( <b>please list</b> )	<input type="checkbox"/> Reflux	<input type="checkbox"/> Irritable Bowel
<input type="checkbox"/> Coeliac	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Eye disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Stroke

Please list any other illness you may have,

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Are you allergic to any of the following (**please tick**)

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex	<input type="checkbox"/> Band aids/tape
<input type="checkbox"/> Anti-inflammatory	<input type="checkbox"/> Iodine	<input type="checkbox"/> Food allergy (Please list)
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Seafood/Shellfish	<input type="checkbox"/> Hay fever

Please list all allergies to Medication or Food that you may have:

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### Women only

Date of the first day of your last period:	Are you pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N
Number of Pregnancies:	Are you breast feeding: <input type="checkbox"/> Y <input type="checkbox"/> N
Number of Live Births:	Are you experiencing any breast tenderness, lumps or nipple discharge of your breasts? <input type="checkbox"/> Y <input type="checkbox"/> N

## IV CONSENT FORM

As part of your procedure today we may be required to inject you with an x-ray dye known as contrast medium. This dye allows us to examine specific parts of your body as requested by your doctor. Although the injection is very safe, it is possible that you'll experience some minor complications. To determine if the dye is appropriate for you, we therefore ask that you answer the following questions accurately & honestly.

1. Have you ever received an injection of contrast medium (x-ray dye)? Yes /No
2. If you have received the injection of contrast dye, did you experience a reaction? Yes /No
3. If yes, please describe what happened: \_\_\_\_\_
4. Are you allergic to any drugs or food? Yes /No  
 If yes, please list them for us: \_\_\_\_\_

Please indicate if any of the following conditions apply to you by circling the appropriate response:

- |   |                |
|---|----------------|
| <b>Diabetes</b>                                     | Yes / No _____ |
| <b>Asthma</b>                                       | Yes / No _____ |
| <b>Renal (Kidney) Disease</b>                       | Yes / No _____ |
| <b>Multiple Myeloma (cancer of plasma cells)</b>    | Yes / No _____ |
| <b>Liver Failure</b>                                | Yes / No _____ |
| <b>Sickle Cell (abnormal haemoglobin cell type)</b> | Yes / No _____ |
| <b>Hepatitis</b>                                    | Yes / No _____ |
| <b>HIV</b>  | Yes / No _____ |
| <b>Phaeochromocytoma (adrenal gland tumour)</b>     | Yes / No _____ |
| <b>Heart Disease</b>                                | Yes / No _____ |
| <b>Pregnant</b>                                     | Yes / No _____ |
| <b>Breast Feeding</b>                               | Yes / No _____ |

## IMPORTANT INFORMATION

There are some side effects and complications that may occur after having an injection of contrast medium. The **most common side effects** experienced are:

- A hot flush, particularly in the pelvic region
- A funny (metallic) taste and/or smell
- A mild sensation of urination

There are also some **uncommon side effects** which include:

- Nausea, which passes quickly
- Vomiting
- Hives (itchy red spots)
- Dizziness

In **very rare cases**, more severe reactions have been recorded. These include:

- Difficulty breathing
- Shock
- Convulsions
- Cardiac and/or respiratory arrest

-In **extremely rare cases**, a severe reaction can result in death

**There is a small risk of contrast medium leaking into the surrounding tissues at the injection site. This is generally only a small amount. Whilst all care will be taken to avoid this, if it should happen then you may need treatment for this including X-Ray to assess quantity, cold compresses and also simple pain killers. If you have any pain during the contrast medium injection, please let our staff know immediately.**

**Should you have any questions or concerns about this information / consent form, please do not hesitate to speak with a member of our staff. When you are ready, please sign and date where indicated and return this form to reception.**

I \_\_\_\_\_ understand the need for a contrast injection and have been informed of the possible risks and side effects. I agree to receiving the contrast injection if required for my procedure.

PATIENTS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_