RADIOLOGISCHE PRAXIS
HOFBAUER DANZ FISCHER

Name: _____ First name: _____ Date of birth: _____

Home adress: _____

Phone number: _____ Weight: _____

Refering doctor: _____

Insurance: _____

For women:		**YES**	**NO**
Your last period: _____	Are you pregnant:	☐	☐

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1. **Do you have a history of allergies** (of food, flowers, medicaments – especially **iodine**)?		☐	☐
What kind of allergies : _____			
2. Did you ever get an X-Ray with contrast (upper GI, thyroid-scan, bone-scan, CT of the abdomen, CT of the pelvis, ….) ?		☐	☐
3. Did you ever show any **reaction to contrast media**?		☐	☐
What kind of reaction? _____			
4. Do you suffer from:	Diabetes?	☐	☐
	Hyper-function of the thyroid?	☐	☐
	Restricted function of the kidneys	☐	☐
5. Do you have a pacemaker?		☐	☐
6. Did you have any other operation on your heart, for example:			
Stent? Bypass?	Artificial heart valve?	☐	☐
7. Do you have a tattoo or a piercing or a permanent make up?		☐	☐
8. Do you have metal in your body (prosthesis, operation-clip, other)?		☐	☐
9. Do you suffer from hepatitis or tubercolosis? Are you HIV-positive (AIDS)?		☐	☐

Date: _____ Signature: _____

Stand: 27.12.2018