

**THE COLUMBIA MEDICAL GROUP, P.A.**

4540 Trenholm Road  
Columbia, South Carolina 29206

**Patient Medical History and Contrast Assessment**

**Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

Please answer the following questions about your health.

Please circle the correct answers:

**YES**      **NO**      1. Do you have a history of allergies to any food or medications?  
\_\_\_\_\_  
\_\_\_\_\_.

**YES**      **NO**      2. Have you ever had CT or IVP contrast (dye)?  
\_\_\_\_\_.

**YES**      **NO**      3. Have you ever had a reaction to CT or IVP contrast (dye)?  
What type of reaction occurred?  
\_\_\_\_\_  
\_\_\_\_\_.

**YES**      **NO**      4. Do you have a history of kidney disease or had a kidney removed?  
\_\_\_\_\_.

**YES**      **NO**      5. Are you a diabetic?

**YES**      **NO**      6. What are you taking for your diabetes?  
\_\_\_\_\_  
\_\_\_\_\_.

**YES**      **NO**      7. Do you have a history of Sickle Cell Disease?

**YES**      **NO**      8. Is there any possibility that you may be pregnant?

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Information verified by:** \_\_\_\_\_  
Signature & Title