McLAREN IMAGING CENTER
501 S. Ballenger Hwy., Suite B • Flint, MI 48532
810-342-4800

IVP WORKSHEET

1. Does the patient have difficulty urinating? Yes _____ No _____

2. Have to get up at night to urinate? Yes _____ No _____

3. Pain? Yes _____ No _____

   Where? _____

4. Fever? Yes _____ No _____

5. Blood or Pus in the Urine? Yes _____ No _____

6. Any prior x-ray studies using contrast? Yes _____ No _____

7. Any reactions with above such as hives, fainting, difficulty breathing, convulsions, severe vomiting?

   Yes _____, If yes, what? _____ No _____

8. Is there a history of epilepsy or asthma? Yes _____ No _____

9. Creatinine, bun or npn? Yes _____ No _____

10. Could patient be pregnant? Yes _____ No _____

11. Allergies? Yes _____ No _____

12. Are you Diabetic? Yes _____ No _____

13. Do you take insulin? Yes _____ No _____

14. Any kidney, bladder or prostate surgery? Yes _____ No _____

Patient Name: _____ Date: _____ / _____ / _____

Time Out:_____

Date: _____ / _____ / _____

Time: _____

Signature: _____

PT.

MR.#/P.M.

DR.