Saint Clare's Health

PATIENT LABEL

# RADIOLOGY DEPARTMENT MEDICAL/MEDICATION HISTORY FORM

Patient Name_____ DOB_____ ❒ Male ❒ Female

Are you under the care of a physician? ❒ Yes ❒ No If yes, for what condition(s)?_____

Past medical history _____

_____

_____

**Allergies?** ❒ Yes ❒ No **Height** _____ **Weight** _____ lbs

| **SPECIFIC ALLERGY** (medication, food, natural supplements) | **REACTION/SIDE EFFECTS** |
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| Allergy to Latex? *Institute Latex Allergy Protocol | ❒ Yes | ❒ No | Are you pregnant? | ❒ Yes | ❒ No |
| Reaction to anesthesia? | ❒ Yes | ❒ No | Are you breastfeeding? | ❒ Yes | ❒ No |
| Family history of reaction to anesthesia? | ❒ Yes | ❒ No | Artificial valves or joints? | ❒ Yes | ❒ No |
| Reaction to medical or dental treatments? | ❒ Yes | ❒ No | History of Rheumatic Fever | ❒ Yes | ❒ No |

## CURRENT MEDICATIONS

**Include:** Over-the-counter, patches, inhalers, eye drops, birth control & natural supplements

**Information Source:** ❒ Patient ❒ Family Member ❒ Other _____

| MEDICATION/DRUG NAME | DOSE | ROUTE | FREQUENCY | LAST TAKEN date/time |
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**Patient Signature:**_____ **Date:**_____

**Technologist Signature:**_____ **Date:**_____ **Time:**_____

**RN/Physician Signature:**_____ **Date:**_____ **Time:**_____