



Name: _____

Date: _____

Please answer the following questions by circling your choice:

1. Any medical changes, medication changes, or hospital visits? YES NO
2. Are you allergic to: Contrast /Dye Latex Betadine Shellfish Tape
3. Have you eaten or drank within the past 6 hours? YES NO
4. Do you have a driver with you today that is staying for the entire office visit? YES NO
5. Any history of bleeding or clotting disorders? YES NO
6. Any chance of pregnancy? YES NO
7. Are you diabetic or have high blood sugar levels? YES NO
8. **Circle any of the following medications you have taken in the past 2 weeks.** Failure to do so accurately may increase the risk of procedural complications:

Aspirin/ Ecotrin

Coumadin/ Warfarin

Plavix / Clopidogrel

Ibuprofen / Advil / Motrin

Xarelto / Rivaroxaban

Aggrenox

Naproxen / Naprosyn / Aleve

Lovenox / Enoxaprin

Pradaxa / Eliquis

Volteran / Diclofenac

Heparin

Pletal

Indomethacin / Indocin

Fragmin

Brilinta

Mobic / Meloxicam

Arixtra

Effient / Prasugrel

Piroxicam / Feldene

Argatroban

Ticlid

Alka-Seltzer

Fish Oil / Krill Oil

Ginger / Garlic /Ginkgo / Ginseng

Emergency Contact: _____

Phone: _____

Patient Signature: _____

Date: _____

