RADIOLOGY ASSOCIATES of HARTFORD, P.C.

Avon • 35 Nod Road
Bloomfield • 673 Cottage Grove Road
Enfield • 9 Cranbrook Blvd
Glastonbury • 31 Sycamore Street
Rocky Hill • 476 Cromwell Avenue

Phone: (860) 969-6400
Fax: (860) 969-6392

Medication Reconciliation

Patient Name: _____ **D.O.B.:** _____ ☐ **Male** ☐ **Female**

Date: _____ **Exam:** _____

MEDICATION PROFILE

List all medications you take, including prescriptions, OTC, herbals inhalers and supplements.

Medication/Supplement	*Dose*	*Frequency (times per day)*	*Last Dose-Date/Time*

PLEASE "CHECK" THE FOLLOWING QUESTIONS

Are you allergic to any medication / food? ☐ Yes ☐ No If yes list _____

Have you had IV contrast before? ☐ Yes ☐ No Did you have a problem with the injection? ☐ Yes ☐ No

Are you a diabetic? ☐ Yes ☐ No Do you take any Metformin medication? ☐ Yes ☐ No

Do you have heart disease? ☐ Yes ☐ No Do you have high blood pressure? ☐ Yes ☐ No

Do you have any kidney disease or have had kidney surgery (including kidney removed)? ☐ Yes ☐ No

Do you have a history of lung disease, hay fever or asthma? ☐ Yes ☐ No

Previous Surgeries on area of exam. _____

Is there any chance you are pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No LMP _____

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that I may receive an intravenous injection depending on the exam requested by my referring physician.

Patient Signature: _____ **Date:** _____

Technologist Signature: _____ **Date:** _____

☐ As a result of your visit, there are no changes to your medications.
☐ As a result of your visit, make the following changes _____

Technologist/MD Signature: _____