



Bookings Tel No: 020 7637 2888 Bookings Fax No: 020 7637 5888

PLEASE COMPLETE ALL SECTIONS OF THIS QUESTIONNAIRE - THANK YOU

Patient's surname: _____
First name: _____ Date of birth _____

PLEASE TICK

Do you have any allergies: YES NO

If YES please give details: _____

Have you ever had an injection in an X-ray/scanning department? YES NO

Did you experience an adverse reaction? YES NO

If YES please describe what happened: _____

Do you have kidney disease or high blood pressure? YES NO

Are you diabetic? YES NO

If YES do you take insulin or tablets? YES NO

Are you epileptic? YES NO

Do you suffer from asthma? YES NO

Do you have heart disease? YES NO

Do you have angina? YES NO

Is there any possibility you may be pregnant? YES NO

Date of LMP: _____

Are you breast feeding? YES NO

Do you have glaucoma? YES NO

Will you be driving after this procedure? YES NO

Patient's signature: _____ Date: _____
Staff member signature: _____