

**IVP
CLINICAL INFORMATION SHEET**

Name _____ Age _____ Today's Date _____

Sex _____ Weight _____ Referring Physician: _____

1. Why are you having this test? _____

2. Do you have back pain? _____ If yes, when: _____

Where: _____

3. Indicate symptoms *please write "YES" next to all that apply*):

a. _____ Blood in urine Visible

b. _____ Sinusitis

c. _____ Fever

d. _____ Nausea

e. _____ History of trauma

f. _____ Vomiting

g. _____ Dizziness

h. _____ Seizures

i. _____ Memory loss

j. _____ Hearing loss

k. _____ Facial Pain

l. _____ Numbness

m. _____ Tingling

n. _____ Double vision

o. _____ Blurred vision

p. _____ Speech difficulty

q. _____ Eye muscle weakness

r. _____ Prior surgery? If yes, what type, where: _____

4. Other information/complaints which you feel may be helpful: _____