NUCLEAR MEDICINE ASSOCIATES

Bone Scan Questionnaire

OFFICE USE ONLY
MR#_____
PACS#_____
DOB_____
DATE OF SCAN _____

Name:_____ **Age:** _____ **Referring Physician:**_____

Are you diabetic? YES NO ***Females*** are you pregnant or breast feeding? **YES NO**

Reason for having this scan done?

_____

Are you currently experiencing any bone pain from: arthritis, broken bones, recent trauma, or orthopedic surgeries? Explain?

_____

_____

_____

_____

_____

Do you have joint replacements?

Right Knee_____ **Left Knee**_____ **Approximate Date**_____

Right Hip_____ **Left Hip**_____ **Approximate Date**_____

Other?_____

Have you ever been diagnosed with cancer? Type_____

When were you diagnosed? _____ **Treatment:**_____

Please list prior scans WHERE AND WHEN:

CT:_____

Nuclear Scans:_____

Ultrasounds: _____

MRI's:_____

TECH NOTES _____

_____

_____

INJECTION LOCATION: _____ TECH: _____ TIME: _____