

# 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?

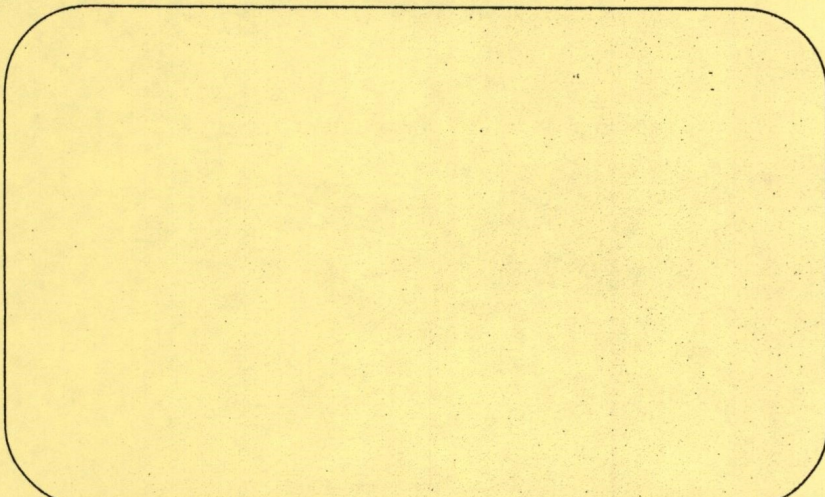
Right Knee \_\_\_\_\_ Left Knee \_\_\_\_\_ Approximate Date \_\_\_\_\_

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: \_\_\_\_\_