NUCLEAR MEDICINE ASSOCIATES

GASTRIC EMPTYING QUESTIONAIRE

OFFICE USE ONLY
MR#_____
PACS#_____
DOB_____

Name:_____ **Age:** _____ **Date** :_____

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

Are you allergic to eggs/wheat? (Circle one) **YES** **NO**
When was the last time you had something to eat? _____

When was the last time you had something to drink? _____

Reason for having this scan done? _______
Symptoms: □Bloating □Prolonged Fullness □ Nausea □ Abdominal pain
□ Other_____

Are you currently on any motility medications? Erthyromyocin, Domperidone (Motilium), Omeprazole, Metaclopramide (Reglan):?_____

Have you had any gastric procedures? _____

In the last week have you had any recent X-Rays or CT scans that required you to drink oral Contrast **YES** **NO**

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Meal Start Time: _____ Finished At: _____

	Time/Camera	Percent Retained
Immediate		
1 Hour		
2 Hour		
4 Hour		

Tech Notes: