



"The Leader in Quality Medical Imaging"

Label

Nuclear Medicine Patient History Sheet

Patient Name: _____ DOB: _____

Weight: _____ Height: _____

(Female Patients)

Is there any chance that you could be pregnant? **Yes No** Are you menopausal? **Yes No**
Are you currently breast-feeding? **Yes No** Last menstrual Period: _____

Reason for this exam: _____

Any current or prior Surgery or biopsies? **Yes No**

If yes, **When**: _____

What type: _____

Chemotherapy? **Yes No** If yes, **When** was last treatment? _____

Radiation Therapy? **Yes No** If yes, **When** was last treatment? _____

Do you have any of the following:

<ul style="list-style-type: none"> ▶ Abdominal Pain Yes No ▶ Bone Pain Yes No ▶ Colostomy Yes No 	<ul style="list-style-type: none"> ▶ COPD/Emphysema Yes No ▶ Diabetes Yes No ▶ Urinary Incontinence Yes No
<ul style="list-style-type: none"> ▶ Artificial Joints Yes No Location: _____ ▶ Arthritis Yes No Location: _____ ▶ Drains/Open Wounds Yes No Location: _____ ▶ Indwelling Catheter or Port Yes No Location: _____ ▶ Infections Yes No Location: _____ ▶ Recent Injuries Yes No Location: _____ 	

Any other major illnesses: _____

Please list medications you are currently taking: _____

Any food or drink today other than water? **Yes No** If yes, what: _____

What time: _____

Would you like us to send a copy of your exam report to your Primary Care Physician?

Dr. _____ (First and last name please)