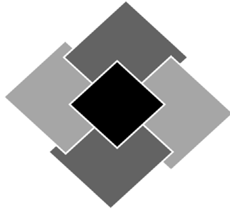

Nuclear Imaging Bone Scan Questionnaire

MRN# DOB:

Patient Name: Date:

Provider:

Patient Name: ______________________________ Ordering Provider: ____________________________

1. Why has your doctor ordered this study? ____

2. Do you have any localized joint pain? YES NO
   - If yes, where? ____

3. Have you ever had an injury to a bone or joint? YES NO
   - If yes, which one and when: ____

4. Have you ever had surgery on a bone or joint? YES NO
   - If yes, which one and when: ____

5. Have you ever had cancer? YES NO
   - If yes, what type and when: ____

6. Do you have arthritis? YES NO
   - If yes, which joint(s): ____

7. Have you had a previous PET/CT Scan? YES NO
   - If yes, when and where: ____

8. Have you ever had a previous bone scan? YES NO
   - If yes, when and where: ____

Female Patients Only:
Are you Pregnant? YES NO Date of last menstrual cycle: _______________

Signature

I have answered all the above questions to the best of my ability.

____ ____________________
Patient Signature (or person authorized to sign for Patient) Date

____
Relationship to Patient if signing for Patient

____ ____________________
Interpreter Signature (or ID# if using service), as applicable Date

To be completed by Technologist only:
Radiopharmaceutical Administered/Amount: TC99HDP=__________ Mci
Route of Administration: Intravenous
Site of Injection: ____________________

Technologist Signature:____