Northeast Radiology

NUCLEAR MEDICINE
CLINICAL QUESTIONNAIRE

Name:_____ Date:_____

Allergies_____

1) Why has your doctor sent you for this test? If any, what is your diagnosis?

_____

_____

_____

2) Please describe your complaints/symptoms._____

_____

_____

3) How long have you had these complaints/symptoms?_____

4) Did these complaints/symptoms come on suddenly or gradually?_____

5) These complaints/symptoms have ____improved, ____remained the same, ____ worsened.

6) Have you had any previous surgery? _____Yes ____No
(if yes, type:_____

7) Have you had any prior tests?

MRI	Date:_____	Place:_____
CT	Date:_____	Place:_____
Ultrasound	Date:_____	Place:_____
Nuclear Medicine	Date:_____	Place:_____
Other_____	Date:_____	Place:_____

What were the results of these tests?_____

_____

8) Are you or could you be pregnant at this time _____Yes ____No
(if yes, please let the technologist or radiologist know before the exam)

NUCLEAR MEDICINE WORKSHEET

NAME:_____ DATE:_____

TECHNOLOGIST:_____

CLINICAL HISTORY:_____

_____

SCAN:_____

RADIOPHARMACEUTICAL:_____

RP DOSE:_____

METHOD OF ADMINISTRATION:_____

SITE OF ADMINISTRATION:_____

TIME OF ADMINISTRATION:_____

INJECTION–TO-IMAGING TIME:_____

I have been informed that the material (IV or ORAL) used for this test contains radioactive material.

LMP_____

Breast Feeding Y N

_____
Patient/Parent /Guardian

_____
Witness

Date_____