NUCLEAR MEDICINE GENERAL HISTORY

Patient Name: ______________________ Medical Record #: ______________________

Imaging Center: ______________________ Date: ______________________

Exam: ______________________ Referring Dr.: ______________________

Patient History:

Reason for Exam: ______________________

Prior Studies for Comparison? (Type, Date, Location)

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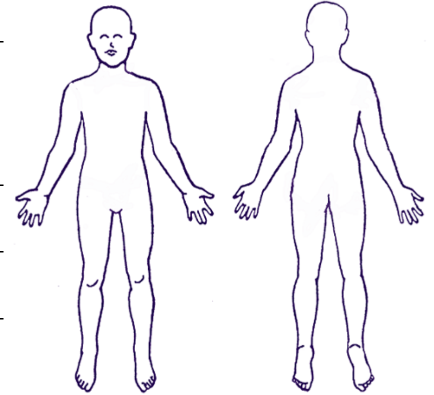
Indicate locations of pain:



List Medications: ______________________

Pain?	☐ Yes	☐ No	Describe:	______________________
Trauma?	☐ Yes	☐ No	Describe:	______________________
Surgery?	☐ Yes	☐ No	Describe:	______________________
Therapy?	☐ Yes	☐ No	Describe:	______________________
Medication Allergy?	☐ Yes	☐ No	Describe:	______________________

Oncology Patients Only:

Chemo?	☐ Yes	☐ No	Describe:	______________________
Radiation?	☐ Yes	☐ No	Describe:	______________________

Females Only: Because radioactive materials will be administered, please answer the following

☐ Yes ☐ No Are you pregnant?

☐ Yes ☐ No Is there any chance you may be pregnant? Last Menstrual Period: ______________

☐ Yes ☐ No Hysterectomy? When? ______________________

☐ Yes ☐ No Menopause? When? ______________________

☐ Yes ☐ No Are you breast-feeding?

Verification of Documented History:

______________________ ______________________

Patient Signature Technologist Signature