

History for Bone Scan

M F

Whole Body _____ Limited _____ 3-Phase _____ SPECT (Circle One)

Date of exam _____ OP ER Room # _____

Patient name _____ Age _____ DOB ____/____/____

MR number _____ Height _____ Weight _____

Females: Pregnant _____ Physician: Dr. _____

Radiopharmaceutical: _____ Dose _____

Diagnosis _____

Chief complaint _____

Bone Pain _____ Where _____ Radiating _____

Broken bones _____ Recent trauma (falls, etc) _____

Arthritis _____ Prosthesis _____

Antibiotic Tx _____ Recent Dental Work _____ Sinusitis _____

Hx of cancer (type, where, when Dx) _____

Chemo, radiation, antibiotic, steroid, diphosphonate, or iron Tx _____ When _____

Any bone, kidney, other surgery, related information _____

Related scans and when (e.g., CT, MRI, PET, previous NM Bone, Gallium, Indium, WBC, ¹³¹I, X-ray) _____

Diabetic _____ Medications _____

Labs: _____ Date _____

Alk Phos _____ LDH _____ BUN _____ Creat _____

Ca²⁺ _____ PO₄ _____ PSA _____ Acid Phos _____

Comments _____

Technologist _____