

**NUCLEAR MEDICINE BONE  
SCAN QUESTIONNAIRE**

PATIENT NAME: \_\_\_\_\_

MEDICAL RECORD NUMBER: \_\_\_\_\_

LMP: \_\_\_\_\_

**REASON FOR BONE SCAN:**

- INFECTION                       CANCER                       BONE PAIN
- FRACTURE                       ARTHRITIS                       BACK PAIN
- REFLEX SYMPATHETIC DYSTROPHY

**WHERE DO YOU HURT?**

\_\_\_\_\_  
\_\_\_\_\_

**ANY PRIOR TEST?     YES     NO**

- ANY NUCLEAR MEDICINE TESTS DONE TODAY OR WITHIN THE LAST 24 HOURS?
- X-RAYS            (Where / Date) \_\_\_\_\_
- CT SCANS            (Where / Date) \_\_\_\_\_
- MRI            (Where / Date) \_\_\_\_\_
- BONE SCAN            (Where / Date) \_\_\_\_\_
- GALLIUM / INDIUM SCAN? (Where / Date) \_\_\_\_\_

**HISTORY**

ANY SURGERIES? \_\_\_\_\_ ANY FRACTURE? \_\_\_\_\_

ANY INFECTIONS? \_\_\_\_\_

- DIABETIC             RENAL INSUFFICIENCY
- PRIOR CHEMO?            WHEN? \_\_\_\_\_
- PRIOR RADIATION?            WHEN? \_\_\_\_\_

