BONE SCAN QUESTIONNAIRE

PATIENT'S NAME_____ DATE_____

PATIENT'S MR#_____ REASON FOR EXAM_____

TECH_____

	YES	NO	COMMENTS
PREVIOUS BONE SCANS?	_____	_____	_____
WHERE? _____			
WHEN? _____			
TRAUMA (last 4-5 years)?	_____	_____	_____
SURGERY (last 4-5 years)?	_____	_____	_____
HISTORY OF ARTHRITIS?	_____	_____	_____
PAST OR PREST CANCERS, TUMORS OR CYSTS?	_____	_____	_____
BROKEN BONES OR FRACTURES (last 4-5 years)	_____	_____	_____
PAIN IN ANY SPECIFIC AREA?	_____	_____	_____
PREGNANT (females 13-50)	_____	_____	_____
BREAST FEEDING?	_____	_____	_____
LAST MENSTRUAL PERIOD	_____	_____	_____

ADDITIONAL COMMENTS _____

_____

_____