SOUTH COAST RADIOLOGY | DARLING DOWNS RADIOLOGY | MACKAY RADIOLOGY

NUCLEAR MEDICINE BONE SCAN PATIENT QUESTIONNAIRE

This information will remain confidential and assist the Radiologist in providing a more thorough report.
To ensure optimal quality of your scan, and to help clear the radiation from your body, please drink plenty of fluids and empty your bladder regularly prior to returning for the second part of your Bone Scan.

NAME: _____ **DATE OF BIRTH:** _____

1. Have you had a previous Bone Scan (not Bone Density) ☐ **YES** ☐ **NO**

   If YES, where _____ and when _____

2. Please list any areas of pain: How long have you had this pain:

   _____ _____

3. Have you had any other investigations (XRAY, CT, MRI, ULTRASOUND) relating to your visit today? ☐ **YES** ☐ **NO**

   If YES, where _____ and when _____

   Have you brought them with you today? ☐ **YES** ☐ **NO**

4. Please give details of accidents that may relate to the onset of your pain (e.g. a fall, car accident).

   Date _____

   _____

5. Have you ever BROKEN or FRACTURED *ANY BONES* in the past? ☐ **YES** ☐ **NO**

   If yes, please list _____ and when _____

   _____ and when _____

6. Please list any sports or leisure activities you participate in.

   _____

7. List any previous surgery on your bones or joints (E.g. Hip/Knee replacements, Laminectomy).

   _____ Date _____

   _____ Date _____

8. Have you ever been diagnosed with Cancer? ☐ **YES** ☐ **NO**

   If yes, what type? _____ and when _____

   List any treatment so far: _____ Date _____

9. List any heart surgery.

   _____ and when _____

10. Do you have arthritis in any joints? ☐ **YES** ☐ **NO**

    If yes, please list _____

11. Please list any other medical conditions (e.g. Diabetes, Osteoporosis).

    _____

12. Are you Right or Left Handed? ☐ **RIGHT** ☐ **LEFT**

13. Is there any chance of you being pregnant? ☐ **YES** ☐ **NO**

PATIENT SIGNATURE: _____

PLEASE RETURN TO THE NUCLEAR MEDICINE WAITING ROOM AT _____