Patient Name: _____ **Today's Date:** _____

When is your follow-up appointment & who is the doctor? _____ Date & Time: _____

Are you allergic to any medications? If yes, please list them: _____

Height: _____ **Weight:** _____

Do you have a **history of tumors or cancer** in your body? If yes, please list them with year of diagnosis:

_____

List any surgeries or biopsies with dates in the past 6 months and any surgery with date related to your cancer: _____

☐ YES ☐ NO **Have you had radiation therapy**? When was your last radiation therapy? _____

_____

What part of your body received radiation therapy? _____

☐ YES ☐ NO **Have you had chemotherapy**? When was your last chemotherapy? _____

When was your last **Nuclear Medicine Bone Scan**? _____ What facility? _____

When was your most recent **PET Scan**? _____ What facility? _____

When was your most recent **CT Scan**? _____ What facility? _____

What part of your body? _____

When was your most recent **MRI Scan**? _____ What facility? _____

What part of your body? _____

SKELETON HISTORY

History:	Yes/No	Body location:	When:
Fractures			
Trauma			
Arthritis			
Prosthesis			
Spine Surgery			
Chest Surgery			

FEMALE PATIENTS:

☐ YES ☐ NO **Is there any possibility you could be pregnant?** **LMP?** _____

☐ YES ☐ NO **Are you breastfeeding?** (Follow special instructions given at scheduling.)

TECHNOLOGIST INJECTION INFORMATION

Questionnaire must be reviewed with patient. ***Technologist Initials:*** _____

(Make sure the questionnaire has been completed, and it matches Intake Form and Body Sheet)

IV Site: _____ Initial Assay; _____ mCi Assay Time: _____

Post Assay: _____ mCi: **Injection Time:** _____

Volume Injected: _____ Injected: _____ mCi **Scan Start Time :** _____

Time between Injection and Start of Exam _____ min **CTDI** _____ **DLP** _____

By (Technologist): _____