

**EASTSIDE DIAGNOSTIC IMAGING, PLLC****NUCLEAR SCAN QUESTIONNAIRE**

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

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

DOB: \_\_\_\_\_

AGE: \_\_\_\_\_

Account Number: \_\_\_\_\_

**SOCIAL SECURITY #:** \_\_\_\_\_

FEMALE / MALE (PLEASE CIRCLE)

REFERRING PHYSICIAN/PHONE NUMBER: \_\_\_\_\_

**IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY.****ARE YOU OR COULD YOU BE PREGNANT?** YES NO

DATE OF LAST MENSTRUAL CYCLE: \_\_\_\_\_

ARE YOU CURRENTLY BREAST FEEDING? YES NO \_\_\_\_\_(INITIAL)

HAVE YOU HAD ANYTHING TO EAT TODAY? YES NO IF YES, WHAT TIME? \_\_\_\_\_

WHAT SYMPTOMS OR COMPLAINTS BROUGHT YOU HERE? \_\_\_\_\_

PLEASE SPECIFY THE LOCATION AND DURATION OF SYMPTOMS: \_\_\_\_\_

WHICH SIDE? RIGHT LEFT OTHER \_\_\_\_\_

**HAVE YOU EVER HAD A SEVERE, LIFE THREATENING OR ANAPHYLACTIC REACTION TO FOOD, MEDICATION OR INSECT OR BUG BITES?** YES NO IF YES, PLEASE EXPLAIN \_\_\_\_\_

DO YOU HAVE ANY ALLERGIES? YES NO IF YES, EXPLAIN \_\_\_\_\_

**HAVE YOU HAD A CONTRAST DYE INJECTION FOR A CAT SCAN OR MRI RECENTLY?** YES NO

IF YES, DID YOU HAVE ANY PROBLEMS OR REACTION TO THIS INJECTION? PLEASE EXPLAIN \_\_\_\_\_

**PLEASE LIST ALL PRIOR SURGERIES:**

[ ] NONE

DATE

[ ] \_\_\_\_\_ / /

[ ] \_\_\_\_\_ / /

[ ] \_\_\_\_\_ / /

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER OR SERIOUS ILLNESS? YES NO

IF YES, HAVE YOU HAD CHEMOTHERAPY? YES NO DATES: \_\_\_\_\_

IF YES, HAVE YOU HAD RADIATION THERAPY? YES NO DATES: \_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?****DO YOU HAVE ASTHMA?** YES NO IF YES, ARE YOU CURRENTLY SYMPTOMATIC? YES NO

HIGH BLOOD PRESSURE? YES NO HEART DISEASE? YES NO

SHORTNESS OF BREATH? YES NO LUNG DISEASE? YES NO

KIDNEY DYSFUNCTION? YES NO

ARE YOU CURRENTLY ON DIALYSIS? YES NO IF YES, DATE OF NEXT SESSION \_\_\_/\_\_\_/\_\_\_

ARE YOU OR HAVE YOU EVER BEEN A SMOKER? YES NO

IF YES, HOW MANY PACKS PER DAY? \_\_\_\_\_

FOR HOW MANY YEARS? \_\_\_\_\_

ARE YOU A DIABETIC?

IF YES, ARE YOU TAKING:

YES NO

GLUCOPHAGE METFORMIN OR GLUCOVANCE

**FOR THYROID SCAN PATIENTS**

ARE YOU CURRENTLY TAKING THYROID MEDICINE? YES NO

WHEN WAS THE LAST TIME YOU TOOK YOUR THYROID MEDICINE? \_\_\_\_\_

**FOR RENAL SCAN PATIENTS**

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS: HIGH BLOOD PRESSURE? YES NO HEART DISEASE? YES NO

IF YES, WHAT MEDICATIONS ARE YOU TAKING? \_\_\_\_\_

WHEN WAS THE LAST TIME THAT YOU TOOK YOUR MEDICATION? \_\_\_\_\_

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT

AS PART OF THIS PROCEDURE I CONSENT TO HAVE INTRAVENOUS RADIOPHARMACEUTICAL CONTRAST MATERIAL GIVEN TO ME. THIS INTRAVENOUS CONTRAST MATERIAL IS ADMINISTERED THROUGH A NEEDLE PLACED IN THE VEIN. THE INDICATIONS AND RISKS OF THIS PROCEDURE HAVE BEEN EXPLAINED TO ME. IT HAS ALSO BEEN EXPLAINED TO ME THAT THE POTENTIAL REACTIONS TO THE RADIOPHARMACEUTICAL CONTRAST, WHILE RARE CAN INCLUDE ALLERGIC REACTION FROM MILD TO SEVERE SWELLING OR INFECTION OF THE INJECTION SITE, BLEEDING, DIFFICULTY BREATHING, LOW BLOOD PRESSURE AND KIDNEY DYSFUNCTION.

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT

TECHNOLOGIST NOTES:

TECH SIGNATURE