NUCLEAR MEDICINE DEPARTMENT OUTPATIENT INFORMATION SHEET

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

Date of Birth: _____ **Patients Weight:**_____

The information you provide here will help us adjust your examination to your individual needs and will aid in the interpretation of your examination. Please complete all sections that apply to you.

Reason the doctor referred you for this test:

_____

_____

Medical History and Major Illnesses:

_____

_____

Please list Surgeries:

_____

_____

FOR FEMALE PATIENTS:
Any possibility of pregnant? Yes____ No____ Date of LMP: _____

FOR STRESS TEST PATIENTS- HAVE YOU EXPERIENCED:

	YES	NO	List medications
Chest pain	_____	_____	
Chest pressure	_____	_____	
Shortness of Breath	_____	_____	
High Blood Pressure	_____	_____	
History of Heart Attack	_____	_____	
History of Asthma	_____	_____	
History of Diabetes	_____	_____	
History of Bypass Surgery	_____	_____	# of Vessels_____
History of Stent placement	_____	_____	# of Stents_____

Allergies:_____

FOR BONE SCAN PATIENTS:
Are you experiencing pain in any area at this time? YES____ NO____ Please explain if yes:

_____

_____

Patient signature: _____

Technologist signature:_____

Time: _____

TIME OUT PROCEDURE COMPLETED BY: _____