Park Avenue Radiologists, P.C.

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

NUCLEAR SCAN 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:

	DATE
[ ] NONE	
[ ] ____________	_____/____/_________
[ ] ____________	_____/____/_________
[ ] ____________	_____/____/_________

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? YES NO IF YES, ARE YOU TAKING: 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 DATE

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.

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

TECHNOLOGIST NOTES:

TECH SIGNATURE