SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: ____ / ____ / ____

PATIENT #: _____
PATIENT NAME: _____
DOB: _____ / _____ / _____ / AGE: _____ / SEX: _____

Nuclear Medicine Bone Scan History

REF PHYS: _____
ACX#: _____

DOSE: _____
INJ. SITE: _____
TECH: _____
LMP: _____ / _____ / _____

DO YOU HAVE PAIN ANYWHERE? ☐ NO ☐ YES
If yes, where? _____
How long have you had the pain? _____

ANY KNOWN INJURY TO THE ABOVE AREA(S)? ☐ NO ☐ YES
If yes, describe: _____
_____

DO YOU HAVE ARTHRITIS? ☐ NO ☐ YES
If yes, where and when was it diagnosed? _____ _____

DO YOU HAVE A HISTORY OF PREVIOUSLY BROKEN BONES? ☐ NO ☐ YES
If yes, which bones and when? _____

DID YOU HAVE ANY SURGERY? ☐ NO ☐ YES
List Surgeries: _____

DO YOU HAVE ANY TYPE OF CANCER? ☐ NO ☐ YES
If yes, where and when was it diagnosed? _____

DID YOU HAVE ANY CHEMOTHERAPY? ☐ NO ☐ YES
DID YOU HAVE ANY RADIATION TREATMENTS? ☐ NO ☐ YES

HAVE YOU HAD ANY PREVIOUS X-RAYS, CT OR MRI SCANS? ☐ NO ☐ YES
If yes, where and when? _____

HAVE YOU EVER HAD A PREVIOUS BONE SCAN? ☐ NO ☐ YES
If yes, where and when? _____

DO YOU HAVE DIABETES? ☐ NO ☐ YES

I have reviewed the above medical history and agree it is correct and complete _____
Patient Signature

COMMENTS :
_____
_____

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