

IMAGECARE
NUCLEAR MEDICINE
BONE SCAN HISTORY

Patient name _____

MRN: _____ DOB: _____

Ordering MD: _____

Date: _____

- Are you having any pain? Yes No

If yes, where in your body: _____

- Have you ever broken any bones? Yes No

If yes, what bones and when: _____

- Have you had any surgery? Yes No

If yes, what type of surgery: _____

- Do you have arthritis? Yes No

If yes, what joints are involved: _____

- Have you ever had cancer? Yes No

If yes, what type of cancer: _____

- Have you ever had radiation treatments? Yes No

If yes, to what area of the body: _____

- Do you have any joint replacements, implants, pacemaker or porta-cath? Yes No

If yes, where: _____