Patient Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Exam ordered: _____ Date:_____

Patient History/Symptoms:_____

Allergies:_____

Last Time Eat or Drink: _____

Surgeries:_____

Recent Diagnostic Scans (CT, X-ray, MRI, Nuc Med, Ultrasound & when):

Type: _____ When: _____

Smoke: _____ Packs per day: _____ Quit: _____ When: _____

Yes	No	History / Symptoms
☐	☐	Pregnant or Breastfeeding
☐	☐	Use Caffeine: Coffee, tea, soda, chocolate
☐	☐	Diabetes
☐	☐	History of Cancer
		Type: _____ When: _____
☐	☐	Radiation Therapy or Chemotherapy
☐	☐	Abdominal Surgery
☐	☐	Liver Disease
☐	☐	Bowel Disease
☐	☐	Kidney Disease/Surgery
☐	☐	Renal Failure/Dialysis
☐	☐	Heart Disease
☐	☐	Pacemaker
☐	☐	Previous Heart Attack (MI)
☐	☐	Heart Catheterization or Stents
		When: _____
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Loss of Strength

Yes	No	History / Symptoms
☐	☐	Blood Thinning Medication
☐	☐	Chest Pain
☐	☐	Arm or Neck Pain
☐	☐	Broken Bones
		Where: _____ When: _____
☐	☐	Recent fall, fractures or trauma
☐	☐	Abdominal Pain
☐	☐	Nausea/Vomiting
☐	☐	Diarrhea
☐	☐	Acid Reflux or Bloating
☐	☐	Gallstones
☐	☐	Shortness of Breath (SOB)
☐	☐	Pulmonary Embolus (PE)
☐	☐	Deep Vein Thrombosis (DVT)
☐	☐	Lung or Respiratory Problems:
		COPD, Emphysema, Bronchitis, Asthma
☐	☐	Fainting Spells
☐	☐	Back Pain
☐	☐	Recent Infections/Fevers

Other Information/Notes: _____

_____

_____

_____

Health ONE North Suburban Medical Center

Nuclear Medicine
Patient Questionnaire

Patient Information/Label

RADS
51244 (03/14)

Current Medication List

☐ Inpatient/ED patient – See Chart ☐ Outpatient – See Below

North Suburban Medical Center is committed to your safety. We require a list of all current medication you are taking prior to administering any medications or contrast for your exam. Please complete the list below or attach a complete list of medications including name, dose, frequency, route, time last taken and physician who prescribes this medicine and sign at the bottom.

☐ I do not take any medications at this time (*sign at bottom)

*Please include all over the counter meds, prescriptions, herbal supplements, vitamins, diet supplements, etc.

Medication Name	Dose (Ex: 3 mg)	Frequency (how often)	Route (by mouth, patch, etc.)	Time Last Taken	Prescribing Physician

*Patient Signature: _____ Date: _____ Time:_____

☐ Reviewed by staff. Proceed with exam if no contraindication present. Follow protocol.

☐ Any contraindication, allergy risk of variation from protocol, notify physician.

Other contraindication: _____

Technologist/RN Signature: _____ Date: _____ Time:_____

Dose: