



**BONE SCAN QUESTIONNAIRE**

PATIENT I.D.

1. Please tell us why you are having this study today? *(check all that apply)*

- Body Pain Location: \_\_\_\_\_ Duration: \_\_\_\_\_
- Recent Injury
- Arthritis
- Cancer Type: \_\_\_\_\_
- Painful or Loose Joint Replacement
- Other \_\_\_\_\_

2. Have you ever had a bone or joint infection?  Yes  No

3. Do you have osteoporosis?  Yes  No

4. If this test is being done for cancer:  
Have you had radiation therapy?  Yes  No  
Have you had any recent chemotherapy?  Yes  No

5. Are you pregnant?  Yes  No

6. Are you nursing?  Yes  No

Is there any other information you would like us to know related to the reason for your visit today? If yes, specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient's Name (*print*)                      Signature                      Date                      Time

\_\_\_\_\_  
Staff Name / Title                      Signature                      Date                      Time