

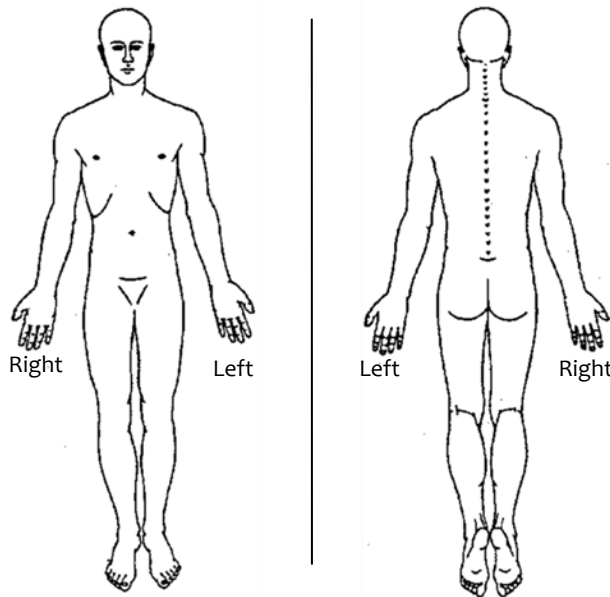
Name		
Date of birth	Weight (kg)	Height (cm)
Telephone	(hm)	(wk)
Contact in case of emergency		
When is the next appointment with your Doctor?		

Please **circle** your response and answer all questions on **both** sides of this page.

Why has your doctor sent you for this scan?		
Have you had a bone scan before?	YES	NO
If YES, when and where?	Which body part?	
Have you brought in previous X-rays, CT, or MRI scans?	YES	NO
Are you having any other additional radiology or pathology procedures done today?	YES	NO
If YES, please describe		
Has your doctor diagnosed you with any of the following?		
- Osteoarthritis	YES	NO
- Rheumatoid arthritis	YES	NO
- Other (please describe)	YES	NO
How long have you had the pain?		
Can you please describe what caused the pain?		
Do you have pain elsewhere?	YES	NO
If YES, please describe		
Have you had any previous bone injuries or fractures?	YES	NO
If YES, please describe		
Have you had any recent falls?	YES	NO
If YES, please describe		
Have you had any previous major surgery? eg. cardiac, mastectomy, back surgery, etc.	YES	NO
If YES, please describe		

Do you have, or have you ever had any type of cancer?	YES	NO
<i>If YES, please describe</i>		
Are you taking any medication related to your current condition?	YES	NO
<i>If YES, please describe</i>		
Have you ever had any joint injections?	YES	NO
<i>If YES, please describe</i>		
Is there any chance you may be pregnant?	YES	NO
Are you breastfeeding?	YES	NO

Please highlight the areas that are painful (*if relevant*) on the diagram below



I have read this form, understand the purpose and the risks of the tests, and consent to the tests being performed.

Patient Name		
Patient Signature <i>(or signature of legal guardian)</i>		Date
Signature of MIT / Radiologist		

OFFICE USE ONLY

ANTICOAGULANTS Yes No

DIABETIC Yes No

ALLERGIES Yes No

DRIVER Yes No

