Hackensack Radiology Group

NUCLEAR EXAM EVALUATION

Last Name	First Name	Middle	Today's Date

Age	Height	Weight

1. Describe what made you go see your doctor: _____

_____

2. How long have you had this problem? _____

_____

3. Have you had surgery <u>on this area</u>? Yes ❑ No ❑
4. If yes, what surgery and when? _____

_____

5. Have you had prior imaging of this area? Yes ❑ No ❑
6. If yes, where and when? _____

_____

7. List all medications you are currently taking (ONLY IF A CARDIAC TEST): _____

_____

_____

8. Do you have a <u>personal</u> history of cancer? Yes ❑ No ❑ Type _____
9. Do you have any other medical conditions? _____

_____

TELEPHONE NUMBER A PHYSICIAN CAN REACH YOU AT IF NEEDED:

Home: _____

Work: _____

Cell: _____