NUCLEAR MEDICINE
Valley Imaging Center

Print Please **Patient ID#:**_____

Exam: _____

Date: _____ Ordering Physician:_____
Office #:_____

Patient Name: _____Age: _____ Sex: Male Female
DOB: _____ Weight: _____ Height: _____
Home Phone #: _____
What are your symptoms/complaints? _____
_____
_____
How long have you had these symptoms? _____
Do you have any food or drugs allergies? _____ If so, please list, and include reactions: _____
_____
What medications are you currently taking? _____
_____
_____
Have you had any surgeries? _____ If yes, what type and when? _____
_____
_____
Date of last menstrual period? _____
Hysterectomy? Yes No Tubal Ligation? Yes No

Do you have or have you had any of the following?

Heart Failure	Yes	No
Renal Failure	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
Liver Problems	Yes	No

Do you or your spouse work at a Nuclear Plant?	Yes	No
Have you taken any Morphine or Demerol in the past 24 hours?	Yes	No
Have you had a CT with contrast in the past 6 weeks?	Yes	No
Are you on any Thyroid medication?	Yes	No

_____
PATIENT SIGNATURE
Comments: _____
_____

Technologist: _____