Summit Diagnostic Imaging Center

Nuclear Medicine Medical History

NAME:_____DATE:____/____/____ DOCTOR:_____

AGE:_____DOB:____/____/____ SS#:_____ HEIGHT:_____ FT_____INCHES

WEIGHT:_____LBS. BRA & CUP SIZE (FEMALE):_____JACKET SIZE (MALE): _____

Please check the appropriate answer for the following questions:

1. Do you have any chest pain? ☐ Yes ☐ No
2. Are you diabetic? ☐ Yes ☐ No
3. Have you had a heart surgery? ☐ Yes ☐ No
4. Have you ever smoked or used tobacco products? ☐ Yes ☐ No
   If yes, how much? _____packs per day for _____years
5. Do you have high blood pressure? ☐ Yes ☐ No
6. Have you had a heart attack? ☐ Yes ☐ No
7. Do you exercise regularly? ☐ Yes ☐ No
8. Have you had a heart catherization? ☐ Yes ☐ No
9. Have you had angioplasty/stent? ☐ Yes ☐ No
10. Do you have a family history of heart disease? ☐ Yes ☐ No
11. Do you have high cholesterol? ☐ Yes ☐ No
12. Had a previous nuclear medicine treadmill? ☐ Yes ☐ No
13. Do you have shortness of breath? ☐ Yes ☐ No
14. Have you taken any form of sedation today? ☐ Yes ☐ No

15. Please list any medications you are currently taking daily (including aspirin):

_____

_____

_____

16. Please list any additional information you think may be important for the physician to know about you:

_____

_____

_____

PLEASE ASK THE TECHNOLOGIST IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT THE EXAMINATION.

DO NOT WRITE BELOW LINE. FOR OFFICE USE ONLY.

PROCEDURE: _____

DIAGNOSIS FOR EXAMINATION:_____

RESTING DOSE: _____mCi Tc99m- Sestamibi at _____ Injection site: _____

STRESS DOSE: _____mCi Tc99m – Sestamibi at _____ Injection site:_____

Calculated Ejection Fraction: _____%

Physician's Notes:_____

_____