



**NUCLEAR MEDICINE QUESTIONNAIRE
FOR FEMALE PATIENTS**
To be completed by all female patients

Patient Name (Please Print): _____ DOB: _____

1. Yes No Have you ever had a mastectomy, lumpectomy, or any other type of breast surgery?

If yes, please check all of the following that may apply.

- Right Mastectomy Lumpectomy Implant Prosthesis
 Left Mastectomy Lumpectomy Implant Prosthesis

2. What is your approximate bra size? _____
(We ask this because breast size can affect the interpretation of your cardiac images.)

3. Yes No NA If you are between the ages of 12 and 54, is there any possibility you could be pregnant?

4. Yes No NA Are you currently breastfeeding?

Patient's signature: _____ Date: _____

*Note: All Female Patients must fill out this form in addition to the Nuclear Medicine Patient Questionnaire.