SAFETY SCREENING QUESTIONNAIRE
Nuclear Medicine

Name :_____ Date of birth: | | | | | | |

First name: _____ Weight : kg

Size : cm

	YES	NO
Do you take anticoagulants ? If yes : which : _____	☐	☐
Do you suffer from any other allergy or do you have asthma? If yes, which: _____	☐	☐
Do you suffer from a kidney disease or kidney failure? If yes, which: _____	☐	☐
Do you have a thyroid disease? If yes, what medication are you taking ?_____	☐	☐
Female patients only : Are you, or could you be, pregnant?	☐	☐
Are you breast feeding?	☐	☐

Remarks / additional information? _____
_____
_____
_____

By signing below, I confirm to have read the information about this exam and understood and correctly answered this questionnaire and give my consent to the conduct this exam. To better assess my case, I accept that Affidea can request previous reports or exams.

Signature of patient: _____ Date : | | | | | | |