**RENAL SCAN QUESTIONNAIRE**

- **Height:**
- **Weight:**
- **Technologist Initials:**

---

**Please drink 8 ounces of water while waiting for the exam to begin.**

1. **What is the reason for this test?** *(Please check all that apply)*
   - [ ] Chronic Kidney (Renal) Failure
   - [ ] Acute Kidney (Renal) Failure
   - [ ] Prior Episode of Renal Failure  
     When: ______________________
   - [ ] Prior Kidney transplant *(Anterior imaging)*
   - [ ] Liver failure
   - [ ] Potential kidney donor
   - [ ] Kidney Trauma / Injury
   - [ ] Kidney Stones
   - [ ] Kidney obstruction *(hydronephrosis)*
   - [ ] Diabetic
   - [ ] Hypertension  
     Most recent Blood Pressure: ______________________
   - [ ] Heart Failure
   - [ ] Other: ______________________

2. **Please describe your symptoms?** *(Please check all that apply)*
   - [ ] None
   - [ ] Pain
   - [ ] Blood in the urine

3. **Please tell us about prior kidney surgery or procedures?** *(Please check all that apply)*
   - [ ] No prior surgery or procedures to the kidneys
   - [ ] Stent
   - [ ] Kidney removed
   - [ ] Bladder removed
   - [ ] Kidney stone removed

---

**Patient’s Name (print)__________________  Signature / Title__________________  Date_________  Time_________**
RENAL SCAN QUESTIONNAIRE

This page is to be completed by Nuclear Medicine Technologist or Registered Nurse.

1. Check for special indications:
   - Reno Vascular Hypertension *(Pre test Captopril may be required)*
   - Hydronephrosis *(Diuretic may be required)*
   - Vesico-ureteric reflux

2. Serum Creatinine Level: __________ mg/dL

3. Details of prior Procedures / Surgery:
   - Transplant When: _______ Where: _______
     Is transplanted kidney from a living donor? Yes No
     Did family member donate? Yes No
   - Renal artery Angioplasty When: _______ Where: _______
   - Urethral Stent Placement When: _______ Where: _______
   - Prior Nephrectomy
   - Prior Cystectomy
   - Nephrostomy? (specify side, and whether tube is open or occluded during imaging)

4. Prior Renal Imaging Studies: *(Please check all that apply)*
   - Ultrasound When: _______ Where: _______
   - CT When: _______ Where: _______

5. Is the patient taking any of the following medications?:
   - Ace Inhibitors *(lotensin, vasotec, accupril, monopril, capoten, altace, prinivil)*
   - Angiotensin II Receptor Blockers *(atacand, toventen, avapro, cozar, micardis, benicar, diovan)*
   - Diuretic *(lasix, diazide, hydrochlorothiazide)*

6. Does the patient have a foley catheter inserted right now? *(Circle one)* Yes No

Additional Information:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(Dose Sticker Here)
RENAL SCAN QUESTIONNAIRE

This page for Captopril Renal Scans Only

Captopril Dose Administered: _______ mg
Time of Captopril Administration: __________________________
Captopril administered by: __________________________, RN

<table>
<thead>
<tr>
<th>Time</th>
<th>Blood Pressure Reading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td></td>
</tr>
<tr>
<td>15 minutes post-Captopril</td>
<td></td>
</tr>
<tr>
<td>30 minutes post-Captopril</td>
<td></td>
</tr>
<tr>
<td>45 minutes post-Captopril</td>
<td></td>
</tr>
<tr>
<td>60 minutes post-Captopril</td>
<td></td>
</tr>
</tbody>
</table>

Tech Name (print)          Signature / Title          Date       Time

Form No. 10745 (1/14/13) Page 2 of 2 Front only