



HISTORY FORM LYMPHOSCINTIGRAPHY

rev:1 1/2026

NAME: _____ DATE: _____

MR# _____ DOB: _____ TECH: _____

INDICATION: _____

RT BREAST _____ LT BREAST _____ BILATERAL BREASTS _____

MELANOMA LOCATION _____

RADIOLOGIST/TECHNOLOGIST INJECTING PATIENT:

METHOD OF INJECTION: US _____ MAMMO _____ NO IMAGE GUIDANCE _____

PRIOR HX OF CANCER (DATE OF DX, CHEMO, RTX) _____

PRIOR EXAMS/STUDIES (WHEN & WHERE)

OTHER MEDICAL HX (HTN, DM, CAD) _____

COMMENTS: _____
