



PET SCAN – PATIENT QUESTIONNAIRE

Name: _____, _____, _____ Today's date: ____/____/____
Last First MI

DOB: ____/____/____ Age: _____ Male [] Female []

Height: _____ Weight: _____ Referring Physician: _____

Please briefly describe the reason for today's exam: _____

Petptquest4/2005

Have you had any of the following?

CT Scan Yes [] No [] If yes, when? _____
What was done? _____
Previous Surgery: Yes [] No [] If yes, when? _____
What was done? _____
Radiation Therapy: Yes [] No [] If yes, when? _____
Body Region(s)? _____
Chemotherapy: Yes [] No [] If yes, when? _____
What Drugs? _____
Diabetes: Yes [] No [] If yes are you insulin dependent? Yes [] No []
Time of last dose: _____
Vaccine Therapy: Yes [] No [] If yes, when? _____
Specify injection sites: _____

Do You Have Any of the Following?

Colostomy Yes [] No [] If yes, location: _____
Ileostomy Yes [] No [] If yes, location: _____
Indwelling Catheter Yes [] No [] If yes, location: _____
Drains/Open Wounds Yes [] No [] If yes, location: _____
Infections Yes [] No [] If yes, location: _____
Pacemaker Yes [] No [] If yes, location: _____
Artificial Joint Yes [] No [] If yes, location: _____
Implants Yes [] No [] If yes, location: _____
Recent Injuries Yes [] No [] If yes, location: _____
Arthritis Yes [] No [] If yes, location: _____
Any Food Today Yes [] No [] If yes, when: _____ what: _____

Any other major illness: _____

FOR OFFICE USE ONLY:

Blood Glucose Level: _____ Action Taken: _____
Assay: _____ mCi FDG Time: ____:____ Post Syringe: _____ mCi FDG Time: ____:____
Inj. Site: _____ Inj. Time: _____ Inj. By: _____