PET / CT Patient Questionnaire

DOS:	Patient:	MRN:	Phone:
Procedure:		Height:	Weight:
Referring Physician:			DOB:

Drug Allergies:

Question	Yes	No	If yes, then…					
Previous Surgery?			When?					
			What was done?					
Radiation Therapy?			When?					
			Body Region?					
Chemotherapy?			When?					
			What Drugs?					
Diabetes?			Insulin?	**Yes:**		**No:**		Time of last Dose?
Do you have Colostomy?			Location:					
Ileostomy?			Location:					
Indwelling catheter?			Location:					
Drains / Open wound?			Location:					
Infections?			Location:					
Pacemaker?			Location:					
Artificial joints?			Location:					
Implants?			Location:					
Recent injuries?			Location:					
Arthritis?			Location:					
Any food today?			When?	What?				
Medications today?								
Claustrophobic?								
Pregnant?			Breast feeding?	**Yes:**		**No:**		
Pain?			Where?					

______________________________ ______________________________

Patient (or Guardian) Signature Date

__________ ______________ ______________________________

(If Guardian, relationship) Witness Signature

PET / CT Use Only			
Glucose:	Dose:		mCi FDG.
Inj. Time:	Inj. Site:	Inj. By:	Scan Time:
Tech Notes:			