



PET-CT Patient Questionnaire

Patient Name: _____ Referring Physician Name: _____

Date: _____ Birthdate: _____ Height: _____ Weight: _____

Reason for Scan: _____ Blood Glucose: _____mg/dl Injection Site: _____

Assay Dose: _____mCi Time: _____ Scan Time: _____

Injection Time: _____ 1st Delay Time: _____

Residual Dose: _____mCi Time: _____ 2nd Delay Time: _____



Is patient diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is patient taking insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient taking oral diabetes medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list medications: _____

Please circle "Yes" or "No"

Food / drink today other than water? Yes No If "yes", what & when? _____

Previous surgery? Yes No Type of surgery & when: _____

Previous radiation therapy? Yes No When & where: _____

Previous chemotherapy? Yes No When & where: _____

Bone marrow stimulation drugs? Yes No List: _____

Recent infections? On antibiotics? Yes No List: _____

Recent biopsy? Yes No List site of bx. & when: _____

Drains / Open wounds / Recent injury? Yes No Location(s): _____

Medicine allergies? Latex allergy? Yes No Details: _____

Strenuous exercise in last 24 hours? Yes No Details: _____

On blood thinners or aspirin? Yes No Details: _____

Arthritis? Yes No Location(s): _____

Joint replacements? Yes No Location(s): _____

Colostomy / Ileostomy? Yes No

Implants / Ports? Yes No Location(s): _____

Indwelling catheter? Yes No Location(s): _____

Pacemaker? Yes No

Is patient pregnant or breastfeeding? Yes No

Has patient received flu or pneumonia vaccine? Yes No When? _____

Does patient have incontinence? Yes No Is patient claustrophobic? Yes No

Has patient had previous CT / MRI / PET-CT? Yes No If yes, what / when / where: _____

