

PET CT Clinical Questionnaire

Patient: _____

DOS: _____

MR #: _____

Exam: _____

Height: _____ Weight: _____

DOB: _____ Sex: Male or Female

Referring Physician (s): _____

Is patient a diabetic?: Yes No

Is patient pregnant?: Yes No

BGL: _____ mg/dl If >180 mg/dl, consult radiologist.

Allergies: _____

Patient last ate at (time): _____

Reason for scan/clinical hx: _____

Patient complaints (areas of pain, hx of trauma, etc.): _____

Hx of ca? (type(s)): _____ Chemo (when): _____ RT (when): _____

Vaccine Therapy (when): _____ Specify injection sites: _____ CGSF Therapy (when): _____

Prior surgeries? (types and dates): _____

Do you have:

Colostomy Y N If yes, location: _____

Ileostomy Y N If yes, location: _____

Indwelling catheter Y N If yes, location: _____

Drains/open wounds Y N If yes, location: _____

Infections Y N If yes, location: _____

Pacemaker Y N If yes, location: _____

Artificial joints Y N If yes, location: _____

Implants Y N If yes, location: _____

Recent injuries Y N If yes, location: _____

Arthritis Y N If yes, location: _____

Any food today Y N If yes, when? _____ What? _____

Any other major illnesses: _____

Medications: _____

Lab results: _____

Prior nuclear scans? (when and where, location of films): _____

Other recent pertinent studies? (when and where, location of films): _____

Technologist Reviewing History: _____

Office Use Only

Dose: _____ mCi FDG Time: _____ Inj. Site _____ Inj. By: _____

