DOCTORS GROOVER CHRISTIE & MERRITT

RADIOLOGISTS

Advancing Medical Imaging Since 1916

PET/CT Patient Questionnaire

Please print clearly.

Patient Name: ____ DOB: ____________

Height ____________ Weight _____________ lbs.

1. Are you diabetic? YES NO
   Are you insulin dependent? YES NO
   Date & time of last insulin dose: ____________________
   Last blood sugar reading: _____________ Date and time: ________________

2. Recent surgeries/biopsies? (Last 12 Months)
   Date: _________________________
   Please describe: ____

3. Are you allergic to any medications? YES NO
   Please list: ____

4. Previous chemotherapy? YES NO
   Most recent completion date: __________________

5. Previous radiation therapy? YES NO
   Most recent completion date: _________________

6. Recent infections? YES NO
   Please describe: ____
   ____

7. When did you last eat or drink? ____

8. Please list all medications that you are currently taking: ________________________________
____
____
____

9. Do you currently experience incontinence? YES NO

Males: Any history of prostate cancer: YES NO

Females: Is there any possibility that you may be pregnant? YES NO

***If you think you may be pregnant or not sure about your pregnancy status, please inform the technologist. ***

10. Do you have a history of any of the following conditions? Please circle YES or NO and provide an explanation below of any YES answer(s).

Tumor	YES	NO
Smoking	YES	NO
Asbestos Exposure	YES	NO
Hypertension	YES	NO
Stroke	YES	NO
Coronary Artery Disease	YES	NO
Closed Head Injury	YES	NO
Seizures	YES	NO
Thyroid Disease	YES	NO
Liver Disease (Cirrhosis)	YES	NO
Memory Problems	YES	NO
Claustrophobia	YES	NO

Explanation:
____
____
____
____

Please provide the date and location of your most recent study:

Type	Date	Location (Facility)
Chest X-ray	__________	______________________
CT	__________	______________________
MRI	__________	______________________
Bone Scan	__________	______________________
PET Scan	__________	______________________
Other	__________	______________________

Additional comments: ____
____
____

Referring physician: ____

Please send extra copies of report to: ________________________________

PATIENT SIGNATURE: ____

DATE: ______________________________