HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PET PATIENT QUESTIONNAIRE

Name: _____ Date of Birth __ __ / __ __ / __ __ __ __

Current Height ___'____" Current Weight _____lbs

Diagnosis/Exam reason: _____

Have you had any recent CT scans? ☐ Yes ☐ No

If Yes, where/when: _____

Have you had any MR scans? ☐ Yes ☐ No

If Yes, where/when: _____

Have you had any recent surgery/biopsy? ☐ Yes ☐ No

If Yes, please list dates & briefly explain: _____

Radiation Therapy? ☐ Yes ☐ No

If Yes, list start & end dates and area of most recent: _____

Chemotherapy? ☐ Yes ☐ No

If Yes, please list most recent treatment dates: _____

Have you had any of the following?			If Yes, location:				If Yes, location:
Drains	☐ Yes	☐ No	_____	Recent Injury/Trauma	☐ Yes	☐ No	_____
Open wounds	☐ Yes	☐ No	_____	Implants/Artificial Joints	☐ Yes	☐ No	_____
Indwelling Catheter	☐ Yes	☐ No	_____	Pacemaker	☐ Yes	☐ No	_____
Infection	☐ Yes	☐ No	_____	Kidney Disease	☐ Yes	☐ No	_____

Do you have Diabetes? ☐ Yes ☐ No If Yes, do you take: ☐ Insulin ☐ Glucophage ☐ Metformin

Are you allergic to Iodine (CT contrast)? ☐ Yes ☐ No

Are you allergic to Gadolinium (MRI contrast)? ☐ Yes ☐ No

Females: Are you Pregnant or Breast Feeding? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

FOR RADIOLOGY DEPARTMENT USE ONLY

*Affix **Dose** Label here*

Tech: _____ Inj Site: _____

Dose: _____mCi @ _____

Radioisotope:

☐ FDG (Glucose) ☐ NaF (Bone)

☐ AMYVID/Florbetapir (Brain) ☐ AV-1451 (Brain)

Glucose: _____mg/dl

GFR: _____ Date: _____

Priors: _____

Diagnostic CT? ☐ Yes ☐ No

Diagnostic MR? ☐ Yes ☐ No

☐ Optiray IV ☐ Readicat PO ☐ Gadolinium IV

☐ Brain ☐ Neck ☐ Chest ☐ Abd

☐ Pelv ☐ Other: _____

☐ Initial ☐ Subsequent

Accession # PET: _____ Accession # CT: _____ Accession # MR: _____

PATIENT HEALTH HISTORY

PS 4297 Rev 01/15/20

[2104]

PATIENT LABEL