

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

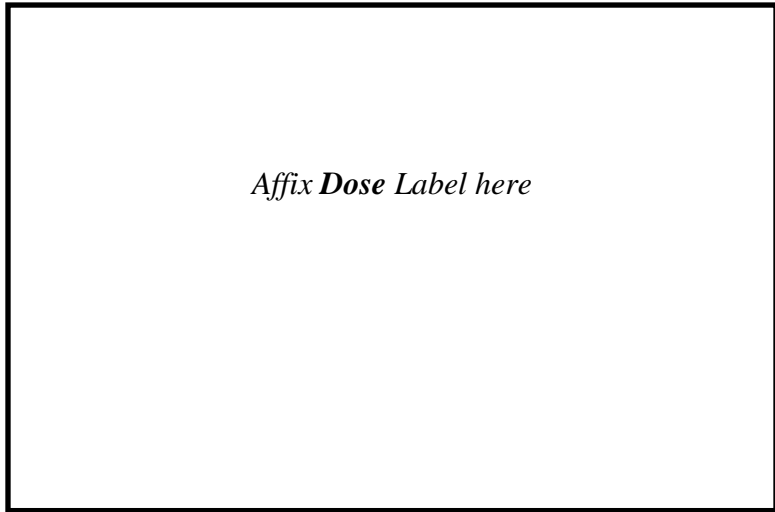
Are you allergic to Iodine (CT contrast)? Yes No

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