

PET PATIENT QUESTIONNAIRE

Name: _____ Date of Birth ____ / ____ / ____

Current Height ____' ____" Current Weight _____ lbs

Diagnosis/Exam reason: _____

Have you had any recent biopsy? Yes No

If Yes, please list dates & briefly explain: _____

Have you had any recent surgery? 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: _____

Immunotherapy or other treatment? Yes No

If Yes, please list most recent treatment dates: _____

Are you currently on a clinical trial? 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

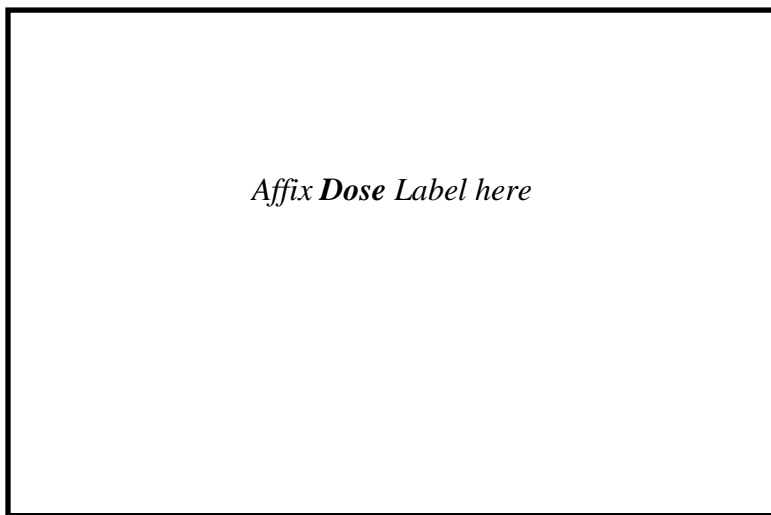
Females:

Are you Pregnant or Breast Feeding? Yes No

Are you post-menopausal? Yes No

Patient Signature: _____ Date: _____ Time: _____

FOR RADIOLOGY DEPARTMENT USE ONLY



Affix Dose Label here

Tech: _____ Inj Site: _____

Dose: _____ mCi @ _____

Radioisotope:

- FDG (Glucose) NaF (Bone)
 Axumin AV-1451 (Brain)
 Amyloid Dotatate

Glucose: _____ mg/dl

GFR: _____ Date: _____

Priors: _____

Diagnostic CT? No W/ W/O W+W/O

Diagnostic MR? No W/ W/O W+W/O

Optiray IV Readicat PO Gadolinium IV

Brain Neck Chest Abd

Pelv Other: _____

Initial Subsequent

Medicare (circle one): PI PS KX

PATIENT HEALTH HISTORY

PS 4297

Rev 11/12/20



[2104]

PATIENT LABEL