HOAG MEMORIAL HOSPITAL PRESBYTERIAN

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) ☐ Cerianna (Breast)
☐ PSMA _____ ☐ NaF (Bone)
☐ Dotatate NET ☐ Amyloid (Brain) _____
☐ _____

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 05/03/22

[2104]

PATIENT LABEL