Your Hospital's Logo Here

PET / CT SCAN QUESTIONNAIRE

■ Street Address ■ City, State Zip ■

PERSONAL INFORMATION

NAME:		DATE OF EXAM:		MED REC #:
DOB:	GENDER: ☐ M ☐ F	HEIGHT:	WEIGHT:	ENCOUNTER #:
HOME PHONE #:		CEL PHONE #:		
REFERRING PHYSICIAN(S):				
REASON FOR EXAM:				
PATIENT COMPLAINTS (Areas of Pain, History of Trauma, etc.):				

QUESTIONNAIRE

1. Previous Surgery?	☐ Yes ----► ☐ No	If "Yes", When?	For What?	
2. Radiation Therapy?	☐ Yes ----► ☐ No	If "Yes", When?	Body Regions?	
3. Chemotherapy?	☐ Yes ----► ☐ No	If "Yes", When?	What Drugs?	
4. Diabetes?	☐ Yes ----► ☐ No	If "Yes", Insulin? ☐ Yes ----► ☐ No	Time of Last Dose:	
5. Vaccine Therapy?	☐ Yes ----► ☐ No	If "Yes", When?	Specific Injection Sites?	
6. cGSF Therapy? (anti-microbial)	☐ Yes ----► ☐ No	If "Yes", When?		
7. Ambulatory?	☐ Yes ☐ No ----►	*IF "**No**", NOTIFY <u>DMS IMAGING</u> WHEN SCHEDULING THE SCAN.*		
8. Porta-Cath?	☐ Yes ----► ☐ No	*IF "**Yes**", NURSING STAFF NEEDS TO ACCESS PORT.*		
9. Pregnant?	☐ Yes ☐ No			
10. Claustrophobic?	☐ Yes ----► ☐ No	*IF "**Yes**", PATIENT SHOULD BRING THEIR MEDICATION(S) WITH THEM DAY OF THEIR SCAN. PATIENT WILL REQUIRE TRANSPORTATION HOME.*		

PART OF THE MEDICAL RECORD

QUESTIONNAIRE *(Continued)*

11.	Diuretics?	☐ Yes ☐ No	
12.	Colostomy?	☐ Yes ----► ☐ No	If "Yes", Location?
13.	Ileostomy?	☐ Yes ----► ☐ No	If "Yes", Location?
14.	Indwelling Catheter?	☐ Yes ----► ☐ No	If "Yes", Location?
15.	Drains / Open Wounds?	☐ Yes ----► ☐ No	If "Yes", Location?
16.	Infections?	☐ Yes ----► ☐ No	If "Yes", Location?
17.	Pacemaker?	☐ Yes ----► ☐ No	If "Yes", Location?
18.	Artificial Joints?	☐ Yes ----► ☐ No	If "Yes", Location?
19.	Implants?	☐ Yes ----► ☐ No	If "Yes", Location?
20.	Recent Injuries?	☐ Yes ----► ☐ No	If "Yes", Location?
21.	Arthritis?	☐ Yes ----► ☐ No	If "Yes", Location?
22.	Any Food Today?	☐ Yes ----► ☐ No	If "Yes", When? / If "Yes", What?

ANY OTHER MAJOR ILLNESSES:

FOR CLINICIAN USE ONLY

DOSE:	TIME:	INJ. SITE:	BY:
_____ mCi FDG			

PART OF THE MEDICAL RECORD