Park Avenue Radiologists, P.C.

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

PET/CT SCAN QUESTIONNAIRE

PATIENT NAME: DOB: AGE:

ACCOUNT NUMBER: SOCIAL SECURITY #: FEMALE / MALE (PLEASE CIRCLE)

REFERRING PHYSICIAN/PHONE NUMBER:

Have you ever had a PET scan? YES NO If so, was it at Park Avenue Radiologists, P.C.? YES NO Date

Are you Diabetic? YES NO If so, do you take insulin? YES NO
When did you last get insulin? _____

Have you eaten or drank ANYTHING in the last six hours besides plain water? YES NO
If so, what? _____

Do you have any allergies to medications? YES NO If so, please list:

_____ _____
_____ _____

Do you have any known sites of tumor at present? YES NO
If so, where? _____

Do you have any metal prostheses? YES NO
If so, which part of the body are they located in? _____

Have you had any Surgery or Biopsies in the last six months? YES NO
If so, please list:
Procedure: Date

_____ _____
_____ _____

Have you had radiation therapy in the last six months? YES NO
If so, to what area(s) of the body and when was your last injection? _____
_____

Have you had any vaccines / other injections in the last year? YES NO
If so, to what area(s) of the body and when was your last injection?
Area:_____ Date:_____

Have you had any infections in the last six months? YES NO
If so, please list sites:_____

Have you had any fractures / broken bones in the last six months? YES NO
If so, please list which bone(s):_____

Have you received any growth factors, (GCSF or Neupogen) in the last six months? YES NO
If so, please list site(s) and approximate date of dose:
Site:_____ Date:_____
Site:_____ Date:_____

WOMEN ONLY

Date of last menstrual period: _____
Is there any chance you could be pregnant? (circle one)
Yes (please let the physician/technologist know) No, I had a tubal ligation and/or a hysterectomy
No, I am postmenopausal (your menstrual periods have stopped) No, I use birth control
No, I am currently on chemotherapy or radiation therapy No, I had a negative pregnancy test on: _____
Are you currently nursing? NO YES (If yes, please let the technologist know)

I attest that the information I have provided on this form is true to the best of my knowledge.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT DATE

TECHNOLOGIST NOTES:

TECH SIGNATURE: