



## PET/CT INFORMATION SHEET (Page 1 of 2)

Patient's Name: \_\_\_\_\_ Age \_\_\_\_\_

Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight \_\_\_\_\_

Reason for PET/CT Scan: \_\_\_\_\_

Have you had a PET or PET/CT Scan before?  Yes  No

If yes, when and where? \_\_\_\_\_

Have you had a surgery or biopsy? If yes, what type and when?  Yes  No

Please list type of surgery and surgeon: \_\_\_\_\_

Do you have any history of cancer?  Yes  No

Are you taking any steroid medications?  Yes  No

Are you on chemotherapy?  Yes  No

Have you had chemotherapy in the past?  Yes  No

If yes, when was it completed? \_\_\_\_\_

Are you on radiation therapy?  Yes  No

Have you had radiation therapy in the past?  Yes  No

If yes, when was it completed? Who was your treating physician? \_\_\_\_\_

Have you had any recent CT or MRI scans?  Yes  No

If yes, when and where? \_\_\_\_\_

Brief medical history: (Have you suffered any trauma?) \_\_\_\_\_

If a female patient, any chance of pregnancy? \_\_\_\_\_

Blood sugar level: \_\_\_\_\_

Mci's injected: \_\_\_\_\_ Time: \_\_\_\_\_ Site: \_\_\_\_\_

Valium given: \_\_\_\_\_ Injector: \_\_\_\_\_



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Patient's Name: \_\_\_\_\_

Please lists all medications being taken currently: \_\_\_\_\_

Please answer the following questions:

	Yes	No
Are you a diabetic?	___	___
Are you currently taking Glucophage, Metformin, or Glucovance	___	___
Are you pregnant, or have you recently given birth?	___	___
Are you currently breastfeeding/ nursing?	___	___
Have you eaten in the last 4 hours?	___	___
Have you ever had difficulty having an IV started (bad veins)	___	___
Do you have a vascular access device? (Example: Portacath: Hickman Catherter, PICC Line)	___	___
Have you had any Barium exams in the last week?	___	___
Do you have any allergies to food or medicine?	___	___
If yes, please list: _____		

Have you ever had a Diagnostic Procedure during which you received IV contrast or "DYE"?

If yes, please list type of test: \_\_\_\_\_

If you have had a prior injection of contrast, did you have any Difficulty at all?	___	___
Do you have any of the following conditions?	___	___
Bronchial Asthma	___	___
High Blood Pressure	___	___
Recent Heart Attack	___	___
Angina	___	___
Heart Failure/ Arrhythmia	___	___
Diabetes Mellitus	___	___
Kidney Failure	___	___
Sickle Cell Anemia	___	___
Multiple Myeloma	___	___
Pheochromocytoma	___	___

Please list any other health conditions you may have. \_\_\_\_\_