PET CT SCAN – Questionnaire

Patient Name: ____________________________ **Sex**: Male Female
Weight:________ **Height:**___________

Have you ever been diagnosed with cancer? Yes No If so, when? ________________

If Yes, in what part of your body?____

Previous Surgery Yes No If yes, when?____
What was done?______________________________________

Radiation Therapy Yes No If yes, when?____
Body region(s)?______________________________________

Chemotherapy Yes No If yes, when?____

Vaccine Therapy Yes No If yes, when?____
Specify injection sites:___________________________________

Do you have allergies to medication? Yes No If yes, what? ____________________________
Do you have allergies to iodine? Yes No

Do you have?

Laryngnotomy:	Yes	No	
Trachestomy:	Yes	No	
Collostomy/Ileostomy:	Yes	No	
Diabetes:	Yes	No	If yes, medication:_________________
Kidney Disease:	Yes	No	
Indwelling Catheter:	Yes	No	
Drains/Open Wounds:	Yes	No	If yes, location:____________________
Infections:	Yes	No	If yes, location:____________________
Pacemaker:	Yes	No	
Artificial joints:	Yes	No	If yes, location:____________________
Implants:	Yes	No	If yes, location:____________________
Recent Injury:	Yes	No	If yes, location:____________________
Arthritis:	Yes	No	If yes, location:____________________
HIV+:	Yes	No	
Hepatitis B or C:	Yes	No	
High Blood Pressure:	Yes	No	
Heart Disease:	Yes	No	

If female: Are you menstruating? Yes No Date of last menstrual period:___________
Are you pregnant? Yes No Breast feeding? Yes No

Will you return to see your doctor today? Yes No
If not, when is your follow up appointment?____
Please list any relevant symptoms you are having and the medications you are taking:
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