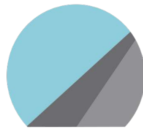

CMI
CASCADE
MEDICAL IMAGING

PET SCAN ~ PATIENT QUESTIONNAIRE

Name: ____________________________, ____________________________, _________ Today's Date:____/____/______
Last First MI

DOB: _____/_____/________ Age: ______________ ☐ Male ☐ Female

Height: ____'______" Weight:____________ Referring Physician:____

☐ **Yes** ☐ **No** **Are you pregnant or is there a possibility that you could be pregnant?**

Please briefly describe the reason for today's exam:____

Have you had any of the following?

CT Scan	☐ Yes	☐ No	If yes, when?________________________________
			What was done?______________________________
Previous Surgery:	☐ Yes	☐ No	If yes, when?________________________________
			If yes, when?________________________________
Radiation Therapy:	☐ Yes	☐ No	If yes, when?________________________________
			Body Region(s)?______________________________
Chemotherapy:	☐ Yes	☐ No	If yes, when?________________________________
			What Drugs?__________________________________
Diabetes:	☐ Yes	☐ No	If yes, are you insulin dependent? ☐ Yes ☐ No
			Time of last dose:___________________________
Vaccine Therapy:	☐ Yes	☐ No	If yes, when?________________________________
			Specify injection sites:_____________________

Have you had any of the following?

Colostomy	☐ Yes	☐ No	If yes, location:____________________________
Ileostomy	☐ Yes	☐ No	If yes, location:____________________________
Indwelling Catheter	☐ Yes	☐ No	If yes, location:____________________________
Drains/Open Wounds	☐ Yes	☐ No	If yes, location:____________________________
Infections	☐ Yes	☐ No	If yes, location:____________________________
Pacemaker	☐ Yes	☐ No	If yes, location:____________________________
Artificial Joint	☐ Yes	☐ No	If yes, location:____________________________
Implants	☐ Yes	☐ No	If yes, location:____________________________
Recent Injuries	☐ Yes	☐ No	If yes, location:____________________________
Arthritis	☐ Yes	☐ No	If yes, location:____________________________
Any Food Today	☐ Yes	☐ No	If yes, when:__________________ What?______________

Any other major illness:____

FOR OFFICE USE ONLY:

Blood Glucose Level:____________________________ Action Taken:______________________________

Assay:__________ mmCiFDG/NaFl Time:_____:______ Post Syringe:________________ mCi FDG Time _____:______

Inj. Site:______________________ Inj. Time _____:______ Inj. By:__________________Inj. Dose___________mCi

Scan Start time:_____________ Protocol(s) used: _____________ Time/Bed:____________________ # of Beds:__________