BRAIN PET/CT SCAN QUESTIONNAIRE

PATIENT GENERAL INFORMATION

NAME: _____
Last Name First Name Suffix

SEX : F M	AGE: _____	DATE OF BIRTH: _____/_____/_____ MONTH DAY YEAR	WEIGHT IN LBS : _____

ADDRESS: _____
Street Name Number City State Zip Code

EMAIL: _____

PHONE NUMBER (1): _____ PHONE NUMBER (2): _____

PATIENT MEDICAL HISTORY

HAVE YOU PREVIOUSLY HAD ANY IMAGING DONE AT SCANTIBODIES? YES | NO ¿WHICH? _____

NAME OF REQUESTING PHYSICIAN FOR PET/CT SCAN: _____

PHYSICIANS PHONE NUMBER: _____ PHYSICIANS EMAIL: _____

MEDICAL DIAGNOSIS/TYPE OF CANCER:

REASON FOR THE STUDY:

Have you received **CHEMOTHERAPY**?	YES	NO	Are you able to move around by yourself?	YES	NO
DATE OF LAST SESSION: _____/_____/_____ MONTH DAY YEAR			Do you use any assistance device to move?	YES	NO
			If so, state device needed. _____		
Have you received **RADIATION THERAPY**?	YES	NO	Are you currently hospitalized?	YES	NO
DATE OF LAST SESSION : _____/_____/_____ MONTH DAY YEAR			Do you require supplemental oxygen?	YES	NO
			Women, are you currently pregnant or lactating?	YES	NO
In which part of the body did you receive radiation therapy? _____			Do you suffer from allergies?	YES	NO
			If so, state allergies. _____		
Are you able to understand /follow instructions?	YES	NO	Are you bedridden?	YES	NO
Are you left-handed?	YES	NO	Do you have involuntary movements? If the answer is yes, anesthesia will be necessary.	YES	NO

PLEASE INDICATE ANY SURGERIES UNDERGONE RECENTLY: (Biopsies, tattoos, piercings, dental, any procedure requiring stitches):

TYPE OF SURGERY: _____ **DATE:** _____/_____/_____ MONTH DAY YEAR

Do you suffer from **DIABETES**? : **YES** **NO**
If so, please indicate treatment used for your diabetes: _____

Please indicate your glucose levels for the last 5 days:

Day 1: _____/ **Day 2:**_____/ **Day 3:** _____/ **Day 4:** _____/ **Day 5:** _____

INVOICE INFORMATION – IF NEEDED

NAME: _____
Last Name First Name Suffix

TAX ID NUMBER: _____ EMAIL: _____

PATIENT SIGNATURE	**DATE** _____/_____/_____ MONTH DAY YEAR