



FULL BODY 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. _____

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