

## **PET/CT Patient Questionnaire**

Name: \_\_\_\_\_

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

**Have you had a PET/CT scan before? YES \_\_\_\_\_ NO \_\_\_\_\_**

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

**Have you had prior Surgery or a Biopsy? YES \_\_\_\_\_ NO \_\_\_\_\_**

If yes:

What kind of operation? \_\_\_\_\_

When was it performed? \_\_\_\_\_

What body part? \_\_\_\_\_

What was the pathology result? \_\_\_\_\_

Additional information: \_\_\_\_\_

**Have you had Chemotherapy? YES \_\_\_\_\_ NO \_\_\_\_\_**

If yes, which agents (if known)? \_\_\_\_\_

Start date: \_\_\_\_\_ End date: \_\_\_\_\_

If currently on chemotherapy, please indicate date of last cycle: \_\_\_\_\_

Did you receive any bone marrow stimulating drug? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, which agent (if known)? \_\_\_\_\_

Date of last administration: \_\_\_\_\_

Were you given a medication to increase your blood count? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, which drug (if known)? \_\_\_\_\_

Date of last administration: \_\_\_\_\_

**Have you had Radiation Therapy? YES \_\_\_\_\_ NO \_\_\_\_\_**

If yes, which body part? \_\_\_\_\_

Start date: \_\_\_\_\_ End date: \_\_\_\_\_

**Are you Diabetic? YES \_\_\_\_\_ NO \_\_\_\_\_**

If yes, how is it treated?

Diet? \_\_\_\_\_ Pills? \_\_\_\_\_ Insulin? \_\_\_\_\_

If insulin, what type and how much? \_\_\_\_\_

What is your fasting blood sugar/glucose? \_\_\_\_\_

**Are you having joint or bone pain? YES \_\_\_\_\_ NO \_\_\_\_\_**

If yes, please specify which joints or what location of bone pain. \_\_\_\_\_

\_\_\_\_\_

**Have you had any intramuscular injections in the last 2 weeks?**

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

If yes, please specify body part used for the injection site. \_\_\_\_\_

**Please indicate if you have the following (specify the location on your body).**

Colostomy/Ileostomy: \_\_\_\_\_

Indwelling catheter: \_\_\_\_\_

Drains/open wounds: \_\_\_\_\_

Infections: \_\_\_\_\_

Artificial joints: \_\_\_\_\_

Pacemaker: \_\_\_\_\_

Implants: \_\_\_\_\_