

EASTSIDE DIAGNOSTIC IMAGING, PLLC**PET/CT SCAN QUESTIONNAIRE**

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

PATIENT NAME: _____

DOB: _____

AGE: _____

ACCOUNT NUMBER: _____

SOCIAL SECURITY #: _____

GENDER: _____

REFERRING PHYSICIAN NAME/PHONE NUMBER: _____

Have you ever had a PET scan? YES NO If so, was it at Eastside Diagnostic Imaging, PLLC? YES NO Date _____

Are you Diabetic? YES NO If so, do you take insulin? YES NO

When did you last get insulin? _____

Have you eaten or drank ANYTHING in the last six hours besides plain water? YES NO

If so, what? _____

Do you have any allergies to medications? YES NO If so, please list:

Do you have any known sites of tumor at present? YES NO

If so, where? _____

Do you have any metal prostheses? YES NO

If so, which part of the body are they located in? _____

Have you had any Surgery or Biopsies in the last six months? YES NO

If so, please list:

Procedure: _____

Date _____

Have you had radiation therapy in the last six months? YES NO

If so, to what area(s) of the body and when was your last injection? _____

Have you had any vaccines / other injections in the last year? YES NO

If so, to what area(s) of the body and when was your last injection?

Area: _____

Date: _____

Have you had any infections in the last six months? YES NO

If so, please list sites: _____

Have you had any fractures / broken bones in the last six months? YES NO

If so, please list which bone(s): _____

Have you received any growth factors, (GCSF or Neupogen) in the last six months? YES NO

If so, please list site(s) and approximate date of dose:

Site: _____

Date: _____

Site: _____

Date: _____

WOMEN ONLY

Date of last menstrual period: _____

Is there any chance you could be pregnant? (circle one)

Yes (please let the physician/technologist know)

No, I had a tubal ligation and/or a hysterectomy

No, I am postmenopausal (your menstrual periods have stopped)

No, I use birth control

No, I am currently on chemotherapy or radiation therapy

No, I had a negative pregnancy test on: _____

Are you currently nursing? NO YES (If yes, please let the technologist know)

I attest that the information I have provided on this form is true to the best of my knowledge.

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT _____

DATE _____

TECHNOLOGIST NOTES:

TECH SIGNATURE: