PET/CT FDG Scan Questionnaire Form

Patient Name: _____ Today's Date: _____

When is your follow-up appointment & who is the doctor? _____ Date & Time: _____

Are you allergic to any medications? If yes, please list them: _____

Height: _____ **Weight:** _____

☐ YES ☐ NO **Are you diabetic?** (Type)_____
☐ YES ☐ NO **Do you take insulin?**
☐ YES ☐ NO **Do you take oral diabetic medications?**
☐ YES ☐ NO **Do you take Neupogen, Leukine or Neulasta after chemo?**
☐ YES ☐ NO **Kidney failure** _____
☐ YES ☐ NO **Reaction- X-Ray Contrast** _____

Do you have a **history of tumors or cancer** in your body? If yes, please list them with year of diagnosis:

_____

List any surgeries or biopsies with dates in the past 6 months and any surgery with date related to your cancer: _____

☐ YES ☐ NO **Have you had radiation therapy**? When was your last radiation therapy? _____

_____

What part of your body received radiation therapy? _____

☐ YES ☐ NO **Have you had chemotherapy**? When was your last chemotherapy? _____

When was your most recent **PET Scan**? _____ What facility? _____

When was your most recent **CT Scan**? _____ What facility? _____
What part of your body?_____

When was your most recent **MRI Scan**? _____ What facility? _____
What part of your body?_____

FEMALE PATIENTS:
☐ YES ☐ NO **Is there any possibility you could be pregnant?** **LMP?** _____
☐ YES ☐ NO **Are you breastfeeding?** (Follow special instructions given at scheduling.)

TECHNOLOGIST INJECTION INFORMATION

Questionnaire must be reviewed with patient. ***Technologist Initials:*** _____
(Make sure the questionnaire has been completed, and it matches Intake Form and Body Sheet)

IV Site: _____ Initial Assay; _____ mCi Assay Time: _____

Glucose Level: _____ Post Assay: _____ mCi: **Injection Time:** _____

Volume Injected: _____ Injected: _____ mCi **Scan Start Time :**_____

Time between Injection and Start of Exam_____min **CTDI**_____ **DLP**_____

Contrast _____cc _____No Contrast ☐ 2D ☐ 3D

By (Technologist): _____