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PET/CT • CT • DIGITAL MAMMOGRAPHY • BONE DENSITY • ULTRASOUND  
LUNG CANCER SCREENING • CARDIAC SCORING

## PET / CT QUESTIONNAIRE

**All new patients, please complete entire questionnaire.**  
**Previous patients, please inform us of anything that has happened since your last scan.**

Today's Date: \_\_\_\_\_

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

Reasons For Having PET/CT Scan: \_\_\_\_\_  
\_\_\_\_\_

When Problem Started: \_\_\_\_\_ Describe: \_\_\_\_\_  
\_\_\_\_\_

Previous Surgical History: (Please be as precise as possible. It does affect the PET interpretation)

Date	Surgery	Location
_____	_____	_____
_____	_____	_____

Date	Biopsy	Location
_____	_____	_____
_____	_____	_____

Do you have any device in your body? (Catheter, pacemaker, stent, shunt, etc. ?)

Date	Device
_____	_____
_____	_____
_____	_____

Have you had any radiation treatment: \_\_\_\_No \_\_\_\_Yes If yes, describe below:

Date	Part of body receiving radiation	(Please be as precise as possible)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you received chemotherapy:  No  Yes If yes, describe below:

Date Medication received (CSA, HGF, etc.)

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Did you have a bone marrow transplant:  No  Yes If yes, describe below:

Date Medication Received (CSA, HGF, etc.)

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Have you ever been diagnosed with the following: (Check all that apply)

- T.S. Sarcoid       Aspergelosis       Histoplasmosis       Epstein-Barr Virus
- Granulomatosis       Atypical T.B.       Glandular fever       Sarcoidosis
- Blood clot in the lung      \_\_\_\_\_

Do you currently have any infection, pain, swelling, redness and fever anywhere in your body:  Yes  No (Including sinus, tooth, etc.)

If yes, where is the infection located: \_\_\_\_\_

If yes, where is the pain located: \_\_\_\_\_

If yes, where is the swelling located: \_\_\_\_\_

If yes, where is the redness located: \_\_\_\_\_

If yes, where is the fever located: \_\_\_\_\_

Are you currently taking steroids: \_\_\_\_\_

Are you currently taking diabetic medication: \_\_\_\_\_

List any other diseases for which you have been diagnosed and when: \_\_\_\_\_

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Medications: Please list any drug or medication that you take.

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## PHYSICIAN'S LIST

Complete the following if you would like us to send the report to your personal fax or e-mail.

- Patients fax number:** \_\_\_\_\_
- Patients e-mail address:** \_\_\_\_\_

Please provide us with COMPLETE full names, phone and fax numbers to ensure that your doctors will receive a copy of your reports.

**Primary care physicians:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

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**Surgeons:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

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**Oncologists:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

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**Radiation Oncologists:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

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**Other physicians to receive reports:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

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**Other physicians to receive reports:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

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