PET/CT FDG Scan Questionnaire Form

PET/CT Manual / Regulatory Affairs
Effective Date: August 1, 2013

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.)

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): ____________________________