Pet/ct FDG Brain-Neuro Questionnaire

PET/CT.POL.002  Effective Date: February 2011

Patient Name: ___________________________  Today’s Date: ________________

☐ Female  ☐ Male  MRN#____________________  Age:____________________

What symptoms are you having? _____________________________
If none, do you know why your doctor ordered this exam? _____________________________

Has your doctor told you that he suspects you may have Alzheimer’s? ☐ Yes  ☐ No  ☐ Possibly  ☐ Not sure what doctor thinks
Has your doctor told you that you have MCI (mild cognitive impairment), but not yet Alzheimer’s? ☐ Yes  ☐ No  ☐ Not sure
Does your doctor suspect dementia, but is unsure if it is Alzheimer’s? ☐ Yes  ☐ No  ☐ Not sure

Please indicate if you have or have had any of the following:

Memory Loss  ☐ Yes  ☐ No

* How long have you had memory loss? __________

* Would you consider your memory loss to be: ☐ Mild  ☐ Moderate  ☐ Severe

* Has your memory loss progressed: ☐ Slowly  ☐ Fast  ☐ Not much change over time

  * Difficulty remembering where you are? ☐ Frequently  ☐ Sometimes  ☐ Almost never

  * Difficulty remembering names or finding words? ☐ Frequently  ☐ Sometimes  ☐ Almost never

  * Difficulty remembering the date? ☐ Frequently  ☐ Sometimes  ☐ Almost never

  * Confusion ☐ Frequently  ☐ Sometimes  ☐ Almost never

Do you shower, dress, & cook on your own? ☐ Yes  ☐ No, I have a helper for those things
Do you manage your own finances? ☐ Yes  ☐ No, I have a helper for that
Do you still drive a car on your own? ☐ Yes  ☐ No
Do you lose things frequently? ☐ Yes  ☐ No
Have you ever had a stroke? ☐ Yes  ☐ No
History of TIA (transient ischemic attack)? ☐ Yes  ☐ No
Parkinson’s disease ☐ Yes  ☐ No
Numbness ☐ Yes  ☐ No  If yes, to what part of the body? ______  ☐ Left  ☐ Right
Localized Weakness ☐ Yes  ☐ No  If yes, to what part of the body? ______  ☐ Left  ☐ Right
Paralysis ☐ Yes  ☐ No  If yes, to what part of the body? ______  ☐ Left  ☐ Right
Slurred Speech ☐ Yes  ☐ No
Loss of Balance ☐ Yes  ☐ No
Difficulty Walking ☐ Yes  ☐ No

Do you have a history of cancer? ☐ Yes  ☐ No  If yes, what type? ______
If yes, has cancer spread to other areas in body? ☐ Yes  ☐ No  If yes, to where? ______
Radiation treatment? ☐ Yes  ☐ No  ☐ Not applicable  If yes, date of last treatment? ______ To what body part? ______
Chemotherapy? ☐ Yes  ☐ No  ☐ Not applicable  If yes, date of last treatment: ______