PET/CT: PATIENT QUESTIONNAIRE

Weill Cornell Imaging
at NewYork-Presbyterian

Name: ____ Date of Exam: __________________________

Date of Birth _____ /_____ /______   Age_____   Sex: M / F   Height: _________   Weight: _____________

Referring Physician ____________________________________ Phone Number ________________________

Have you had a PET scan before? ☐ Yes ☐ No
If yes, where and when? ____

Have you had a prior CT scan or MRI? ☐ Yes ☐ No
If yes, where and when was the most recent? ____

PATIENT HISTORY AND RISK ASSESSMENT FOR CONTRAST MEDIA:

Has patient had a prior x-ray study that required injection of contrast media? ☐ Yes ☐ No

If so, did the patient experience a reaction to the contrast media? ☐ Yes ☐ No

If yes, please specify symptoms:

Mild Reaction:

☐ Itching ☐ Headache ☐ Nausea, vomiting ☐ Shaking

☐ Rash, hives ☐ Chills ☐ Dizziness ☐ Other ___________________

Moderate Reaction:

☐ Generalized urticaria ☐ Severe nasal congestion ☐ Marked swelling: eyes, face

☐ Dyspnea ☐ Brochospasm / Wheezing ☐ Vasovagal response

☐ Hypertension / Hypotension ☐ Tachycardia / Bradycardia

Severe life-threatening reaction:

☐ Laryngeal edema ☐ Profound hypotension ☐ Convulsions

☐ Unresponsiveness ☐ Clinically manifest arrhythmias ☐ Cardiopulm. arrest

Reason for this exam____

Prior **Surgery or Biopsy?** ☐ Yes ☐ No

If yes:

What kind of operation(s)? ____

When was it done? ____

Which body part?____

What was the pathology result? ____

Additional:

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Mark if you have any of the following (please specify location on your body)

☐ Colostomy / ileostomy____________________

☐ Indwelling catheter ____________________

☐ Drains/ open wounds____________________

☐ Infections____________________

☐ Pacemaker____________________

☐ Artificial joints ____________________

☐ Implants ____________________

Prior **chemotherapy** ☐ Yes ☐ No

If yes, which agents (if known)? ____________________
When did it start? ____________________
When did it finish? ____________________
If currently on chemotherapy, please indicate the date of last cycle____________________
Did you receive any bone marrow stimulating drug?
Please specify agent (Neupogen, Epogen) ____________________
Date of last administration:____________________

Prior **radiation** therapy ☐ Yes ☐ No

If yes, which body part? ____________________
When did it start? ____________________
When did it finish ____________________

Ever had any **trauma, fractures, or recent injuries?** ☐ Yes ☐ No
If yes, please list with approximate date(s) and part of the body.

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____

Mark if you have any of the following (please specify how long you had this problem)

☐ Heart disease____________________

☐ Hypertension / High Blood Pressure ____________________

☐ Stroke ____________________

☐ Lung disease ____________________

Lung cancer ☐ Asthma ☐ Bronchitis ☐ Smoker ☐ Yes ☐ No How long?____________________

☐ Kidney disease____________________

☐ Liver disease ____________________

☐ Reflux / heartburn____________________

☐ Thyroid problems____________________

Nodules/inflammation ☐ Hypothyroidism ☐ Hyperthyroidism ☐

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☐ Sinus problems ____

☐ Hernia ____

☐ Skin problems ____

☐ Multiple myeloma or paraproteinemia____

☐ Sickle cell disease ____

Please list your **medications**, and the reason why you take them:
____
____
____

If you are Diabetic, how is your diabetes treated?

Pills? ☐ Yes ☐ No Type______________________

Insulin? ☐ Yes ☐ No How much:______________________

Diet and Exercise? ☐ Yes ☐ No

What is your fasting blood sugar/glucose? ______________________

Are you having joint problems? ☐ Yes ☐ No
If yes,
Please specify which joints ______________________

Please rate the quality of joint pain: Mild ☐ Moderate ☐ Intense ☐

Are you having bone pain? ☐ Yes ☐ No
If yes, location? ______________________

Please rate the quality of bone pain: Mild ☐ Moderate ☐ Intense ☐

Do you have any known allergies (medication, shellfish or other foods)? ☐ Yes ☐ No
If yes, please specify______________________

Any recent intramuscular injection in the last 2 weeks? ☐ Yes ☐ No
Please specify body part and if for vaccine, B12 injection, etc. ______________________

Describe your bowel habits on the scale below:

(Constipation) 1 2 3 4 5 6 7 8 9 10 (Diarrhea)

Are you pregnant? ☐ Yes ☐ No Last menstrual cycle: ______________________

Date Issued: 3/1/07 Date Updated: 4/14/08

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DO NOT WRITE BELOW THIS LINE

Accession Number: ______________________________________

NURSING NOTES:

Blood Glucose: ___________________________

IV site: ____ **Infiltration** ☐ Yes ☐ No

Oral contrast administered by: ____ ☐ RN
Dose and Concentration: ____

Intravenous contrast administered by: ____ ☐ MD ☐ RN
Dose and Concentration: ____

Notes:

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Nurse ____ Signature _______________________________________

Date and time___________________________

PET TECHNOLOGIST NOTES:

Isotope: ______________ Dose: ______________ Post Syringe: ______________ Net Dose: ______________

Time Injection: ______________ Site of Injection ___________________________

Infiltration: ☐ Yes ☐ No

Technical Problems? (Please explain)

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Technologist _________________________

Date and Time___________________________________ Signature _____________________________________

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