Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122
Please bring all completed forms to your appointment

(Office use)

PET/CT: QUESTIONNAIRE/AUTHORIZATION

Name: _____ Date of Exam: _____

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

Referring Physician: _____ Phone Number: _____

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? _____

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)

☐ Lung disease _____

Lung cancer☐ Asthma☐ Bronchitis☐ Smoker: ☐ Yes ☐ No How long? _____

☐ Kidney disease_____

☐ Liver disease _____

☐ Reflux /heartburn_____

☐ Thyroid problems_____

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? _____

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.:_____

FEMALE PATIENTS ONLY

Are you pregnant? ☐ Yes ☐ No

Last menstrual cycle: _____

I authorize Weill Cornell Imaging at NewYork-Presbyterian, its physicians, and other staff to perform the prescribed examination.

Questionnaire Completed By:

_____ _____ _____ /_____ /20_____

Print First and Last Name Signature Date

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DO NOT WRITE BELOW THIS LINE (Office Use Only)

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:

_____

_____

_____

_____

_____

Nurse: _____ Signature: _____

Date: _____ Time: _____

PET TECHNOLOGIST NOTES:

Isotope: _____ Dose: _____ Post Syringe: _____ Net Dose: _____

Time Injection: _____ Site of Injection: _____
Infiltration: ☐ Yes ☐ No

Technical Problems? (Please explain):

_____

_____

_____

Technologist: _____ Signature: _____

Date: _____ Time: _____