Weill Cornell Imaging

NewYork-Presbyterian | Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122

(office use)

PET/CT QUESTIONNAIRE/AUTHORIZATION

Name: _____ **Date of Exam:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Height:** _____ **Weight:** _____

1. Why are you having this exam?

   _____

2. Have you had surgery or a biopsy? ◯ Yes ◯ No
   If YES, What types and when?

   _____

3. Have you had prior chemotherapy? ◯ Yes ◯ No
4. Are you currently on chemotherapy? ◯ Yes ◯ No
   If YES, What was the date of the last cycle?

   _____

5. Have you had any bone stimulating drug (Nuepogen®/Epogen®)? ◯ Yes ◯ No
   If YES, What was the last date you took this drug?

   _____

6. Have you had prior radiation therapy? ◯ Yes ◯ No
   If YES, please answer the following:

   What body part was radiated? _____

   When did radiation start? _____

   When did radiation end? _____

7. Are you diabetic? If YES please answer the following: ◯ Yes ◯ No

   Do you take oral medication for your diabetes? ◯ Yes ◯ No

8. Do you take insulin? ◯ Yes ◯ No

9. What is your fasting blood sugar/glucose? _____

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10. Have you had a recent intramuscular injection in the past 2 weeks? ◯Yes ◯No
    If YES, what type of injection and where was it injected? _____

11. Do you have an allergy to Latex? ◯Yes ◯No

12. Do you have an allergy to iodine? ◯Yes ◯No

13. Do you have a history of Diabetes Mellitus? ◯Yes ◯No
    If YES, are you on any medications? ◯Yes ◯No

14. Do you have a history of kidney disease, kidney failure, transplant kidney tumor and/or kidney surgery/ interventional procedure of any kind? ◯Yes ◯No

15. Do you have high blood pressure (also known as hypertension)? ◯Yes ◯No

16. Have you been told by your doctor that you have protein in your urine? ◯Yes ◯No

17. **Have you ever had an injection of x-ray dye/contrast?** ◯Yes ◯No
    If YES, please answer the following:
    Have you ever had hives following x-ray dye/contrast? ◯Yes ◯No
    Have you ever had shortness of breath following x-ray dye/contrast? ◯Yes ◯No
    Have you ever fainted/collapsed following x-ray dye/contrast? ◯Yes ◯No

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18. **FEMALE PATIENTS**

Is there any possibility that you are pregnant? ◯ Yes ◯ No

Are you breastfeeding? ◯ Yes ◯ No

When was your last menstrual cycle? _____

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

Signature of Patient:
(Parent or Guardian) _____ Date: _____

(office use)

Front Desk Staff:_____ Signature: _____

Technologist:_____ Signature: _____

Nurse:_____ Signature: _____