

OPTIMA DIAGNOSTIC IMAGING

CT • MRI • PET/CT • BONE SCAN

PET Scan Questionnaire

Name: _____ Birthdate: _____ Age: _____ Date of Exam: _____
Height: _____ Weight: _____ Sex: _____ Referring Physician: _____
Reason for Exam: _____
Have you had any recent changes in your history: _____

Have you had:

Previous Surgeries N Y If yes, when and for what: _____
Radiation Therapy N Y If yes, when and what area: _____
Chemotherapy N Y If yes, when: _____

Do you have:

Diabetes N Y Insulin/Glucophage or Metaforum N Y
Dose and time of last dose _____
Allergies N Y If yes, please list _____
Claustrophobia N Y
Colostomy/Ileostomy N Y If yes, location: _____
Internal Catheter N Y If yes, location: _____
Drains/Open Wounds N Y If yes, location: _____
Infections N Y If yes, location: _____
Recent Injuries N Y If yes, location: _____
Arthritis N Y If yes, location: _____
Artificial Joints N Y If yes, location: _____
Pacemaker N Y
Cosmetic Implants N Y If yes, location: _____

Are you Pregnant or Nursing N Y If yes, or think you could be, ***inform Technologist*** before exam

Have you had any food today? N Y If yes, When: _____ What? _____

If you have any other major illnesses please explain: _____

What medications are you taking and the dose: _____

Patient Signature: _____ **Date:** _____

Print Name: _____

Office Use Only TECHNOLOGIST NOTES

NOPR: Patient Verbally Consents: _____ **Patient Verbally Declines:** _____

Glucose: _____
FDG Info: _____ Pre ASSAY: _____ mCi Post ASSAY: _____ mCi

Dose: _____ mCi FDG Time: _____ Injections Site: _____ Injected By: _____