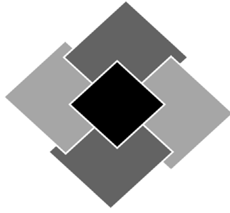

PET CT Questionnaire

MRN# DOB:

Patient Name: Date:

Provider:

Patient Name: ______________________________ Ordering Provider: __________________________
Gender: Female ☐ Male ☐
Reason for today's exam: ____

1. Have you had any recent surgeries? ☐ YES ☐ NO
   If yes, what procedure and when? ____
2. Do you have any infections or open wounds? ☐ YES ☐ NO
   If yes, please describe: ____
3. Have you had any recent chemotherapy or radiation treatments? ☐ YES ☐ NO
   If yes, please describe: ____
4. Have you had a prior PET Scan? ☐ YES ☐ NO
   If yes, when and where: ____
5. Have you had any other imaging done related to this visit? ☐ YES ☐ NO
   If yes, what, when and where: ____
6. Do you have known renal (kidney) function problems? ☐ YES ☐ NO
   If yes, please describe: ____
7. Have you had any prior reaction to iodine containing contrast agents? ☐ YES ☐ NO
   If yes, please describe: ____

Signature

I have answered all the above questions to the best of my ability.

____ ____________________
Patient Signature (or person authorized to sign for Patient) Date

____
Relationship to Patient if signing for Patient

____ ____________________
Interpreter Signature (or ID# if using service), as applicable Date