PARTNERS IMAGING CENTERS

CT / PET - CT Patient History Questionnaire

Patient Name _____ Account # _____

Ordering Physician _____ Exam _____

1. Please list the reason your doctor has orderd this exam.

_____

_____

2. Please list the type(s) and approximate date(s) of any surgery you have had.

_____

3. Have you ever had cancer? YES NO If yes, what type of cancer?

_____

4. Have you ever had radiation Therapy treatments? YES NO When?

5. Have you ever had Chemotherapy treatments? YES NO When?

6. Please list the date and location of any recent X-ray, CT, Ultrasound, Nuclear Medicine, or MRI scan(s) you have had.

_____

7. Do you have, or have you ever had, any of the following:

Asthma	YES	NO	Hay Fever	YES	NO
Lung Disease	YES	NO	Heart Disease	YES	NO
Thyroid Disease	YES	NO	Kidney Disease	YES	NO
Sickle Cell Disease	YES	NO	Multiple Myeloma	YES	NO
Pheochromocytoma	YES	NO	Diabetes	YES	NO
			Oral Insulin Diet	YES	NO

8. Are you allergic to any of the following:

Medication	YES	NO
X-ray Dye (iodine)	YES	NO

Height _____

Weight _____

9. Infections? YES NO

_____ _____

Patient or Guardian Signature Date

PET DOSE _____ mCi 18 FDG @ time _____

INJ Site _____ Glucose _____ mg/dL