PET/CT SCAN EVALUATION

Patient Information

Patient Name _____ Date of Birth _____

Age _____ M / F Height _____ Weight _____

Possibility of Pregnancy? Y / N Breast Feeding Y / N Diabetes? Y / N

Any History of Cancer _____ What kind ? _____

Prior Imaging

Previous CT Y / N When? _____ Where? _____

Previous MRI Y / N When? _____ Where? _____

Previous PET Y / N When? _____ Where? _____

Patient History

Current Medication _____

Radiation Therapy Y / N Current If yes, how many cycles? _____ Stopped when? _____ Location? _____

Chemo Therapy Y / N Current If yes, how many cycles? _____ Stopped when? _____

Vaccine Therapy Y / N Current If yes, how many cycles? _____ Stopped when? _____

Prior Therapies (list) _____

_____

Surgeries (list type and date) _____

_____

Biopsies (list type, date, and results) _____

_____

Injection Site _____

Alllergies	Y / N	Abscess/Infection	Y / N	Asthma	Y / N
Back Pain	Y / N	Drains/Open wounds	Y / N	Colostomy	Y / N
Prosthesis	Y / N	Indwelling catheter (CVC or porta-cath)	Y / N	Ileostomy	Y / N
				Implants	Y / N
		Swollen nodes/lumps	Y / N	Pacemaker	Y / N

Name of Person Taking Patient History Information: _____ Date _____