



PET / NUCLEAR MEDICINE
PATIENT HISTORY / SCREENING

ADDITIONAL EXAMS _____

Patient Name: _____ DOB: _____

Date: _____

PLEASE ATTEMPT TO ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. Have you ever had any of the following imaging studies?

Table with 5 columns: Study Type, Yes, No, When, Where. Rows include CT, PET, MRI, Ultrasound, Nuclear Medicine, and Mammogram.

2. Have you ever been diagnosed with cancer? [] Yes [] No
If so, please list all types you have been diagnosed with:

3. If your diagnosis is melanoma, where was your original site? _____

4. Do you have a history of myeloma? [] Yes [] No

5. Have you received any chemotherapy? [] Yes [] No If so, when? _____

6. Have you ever received any radiation treatments? [] Yes [] No
If so, when and what area of your body? _____

7. Are you currently undergoing radiation treatment? [] Yes [] No Physician: _____

8. Have you had any surgery or biopsies? [] Yes [] No
If so, what type and when? _____

9. Are you a diabetic? [] Yes [] No

(You will be given water to drink while you wait for your exam to begin or, in certain cases, IV fluids may be necessary.)

10. Do you have a history of chronic heart failure or renal failure? [] Yes [] No

11. Do you have renal (kidney) problems or swelling? [] Yes [] No

12. Is there a possibility that you may be pregnant? [] Yes [] No Last menstrual period: _____

13. Are you currently breast-feeding? [] Yes [] No