

**PET/CT CENTER PATIENT
INFORMATION SHEET**
AHMANSON BIOLOGICAL IMAGING
CENTER/NUCLEAR MEDICINE

MRN: _____
Patient Name: _____

(Patient Label)

Referring Physician(s): _____

Height: _____ Weight: _____

1. If you know the reason your doctor ordered this PET/CT study please indicate here:

2. Have you had a CT Scan recently? Yes No

If yes, on what date? _____

If yes, were you given IV contrast? Yes No

3. Have you had previous surgery? No Yes – Date _____

Have you had previous Biopsy? No Yes – Date _____

4. Previous radiation therapy? No Yes – Date _____ to _____

Ongoing radiation therapy? No Yes – Date _____ to _____

5. Previous chemotherapy? No Yes – Date _____ to _____

Ongoing chemotherapy? No Yes – Date _____ to _____

6. Do you have diabetes? Yes No

If yes, do you take insulin? Time of last Insulin dose: _____

Do you take Glucophage or Metformin? No Yes

If yes, time of last dose: _____

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7. Do you receive any treatment by injection into the skin or muscle? Yes No
If yes, specify the location of injection sites(s) and how recent they were given.

Site: _____ Date: _____

8. Do you have any of the following:

Drains/Open Wounds No Yes - If yes, location _____
Infections No Yes - If yes, location _____
Recent Injuries No Yes - If yes, location _____

9. Other major medical illnesses or medical problems (please list here):

10. Have you had any food or beverages, candy (except water or medications) within 6 hours of this Scan?

No Yes – If Yes, how many hours ago? _____ What _____

11. Female patients: Post-Menopausal? Yes No

If no, date of last menstrual period: _____

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____ Date _____ Time _____