PET/CT Questionnaire

Name: _________________________________________
Date of exam: ___________________________________

If you have other scans not done at the JGH bring reports and CDs to your appointment, we do not have them.
Answer all the questions. Do not write “see file.” Use the space at the bottom to provide as much detail as possible.

Height: _________ Weight: _________ Allergies? □ No □ Yes, specify: ________________________

Been diagnosed with cancer? □ No □ Yes, type: _____________________________________________

Had a biopsy? □ No □ Yes, body part, date & results: _________________________________________

Had surgery? □ No □ Yes, types & dates: __________________________________________________

Had injected chemotherapy? □ No □ Yes, date of last treatment: _____________________________

Had pill-form cancer therapy? □ No □ Yes, date of last treatment: __________________________

Had radiation therapy? □ No □ Yes, body part & date of last treatment: _______________________

Had hormonal therapy? □ No □ Yes, date of last treatment: _________________________________

Had bone marrow stimulants? □ No □ Yes, date of last treatment: ___________________________

Had a colonoscopy? □ No □ Yes, results & date: ____________________________________________

Ever smoked? □ No □ Yes, _____ packs per day for _____ years. Quit date: ___________________

Check the boxes if any of the following apply. Specify body parts, details and dates as applicable.

☐ Pregnancy (even possibility of) ☐ Date of last menstruation: _____________________________

☐ Currently breastfeeding or nursing ☐ Fractures: __________________________________________

☐ Diabetes ☐ Trauma or injuries: _________________________________________________________

☐ Diarrhea ☐ Drains or open wounds: ____________________________________________________

☐ Constipation ☐ Infection or fever: _____________________________________________________

☐ Current cold, flu or sore throat ☐ Artificial joints or implants: __________________________

☐ Pleurodesis (for recurrent pleural effusions) ☐ Weight loss, specify: _____________________

☐ Crohn's disease or ulcerative colitis ☐ Pain: ____________________________________________

☐ Sarcoidosis ☐ Lung disease: __________________________________________________________

☐ Gastric reflux (heartburn) ☐ Kidney or liver disease: _________________________________

☐ Sickle cell disease ☐ Skin disease: ____________________________________________________

☐ Thyroid disease (nodules, hypothyroidism, hyperthyroidism, etc.): ______________________

☐ Recent injections (Vit. B12, vaccine, etc.): ___________________________________________

List all other medical conditions, your medications and use this space to provide details to above questions.

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

DO NOT WRITE BELOW THIS LINE. Fasting since: __________ Last insulin or metformin: ________ Sarcoid diet since: _________