

NYU CLINICAL CANCER CENTER

PET/CT Patient Questionnaire

Name: _____ Date of Exam: _____

Date of Birth ____/____/____ Age _____ Sex: M / F Height: _____ Weight: _____

Referring Physician _____ Phone Number _____

Have you had a PET scan before? Yes No

If yes, where and when? _____

Have you had a prior CT scan or MRI? Yes No

If yes, where and when was the most recent? _____

PATIENT HISTORY AND RISK ASSESSMENT FOR CONTRAST MEDIA:

Has patient had a prior x-ray study that required injection of contrast media? Yes No

If so, did the patient experience a reaction to the contrast media? Yes No

If yes, please specify symptoms:

Mild reaction:

- | | | | |
|--------------------------------------|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Itching | <input type="checkbox"/> Headache | <input type="checkbox"/> Nausea, vomiting | <input type="checkbox"/> Shaking |
| <input type="checkbox"/> Rash, hives | <input type="checkbox"/> Chills | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other _____ |

Moderate reaction:

- | | | |
|---|--|--|
| <input type="checkbox"/> Generalized urticaria | <input type="checkbox"/> Severe nasal congestion | <input type="checkbox"/> Marked swelling: eyes, face |
| <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Bronchospasm / Wheezing | <input type="checkbox"/> Vasovagal response |
| <input type="checkbox"/> Hypertension / Hypotension | <input type="checkbox"/> Tachycardia / Bradycardia | |

Severe life-threatening reaction:

- | | | |
|---|--|---|
| <input type="checkbox"/> Laryngeal edema | <input type="checkbox"/> Profound hypotension | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Unresponsiveness | <input type="checkbox"/> Clinically manifest arrhythmias | <input type="checkbox"/> Cardiopulm. arrest |

Reason for this exam _____

Prior **Surgery or Biopsy**? Yes No

If yes:

What kind of operation(s)? _____

When was it done? _____

Which body part? _____

What was the pathology result? _____

Additional:

Mark if you have any of the following (please specify location on your body)

- Colostomy / ileostomy _____
- Indwelling catheter _____
- Drains / open wounds _____
- Infections _____
- Pacemaker _____
- Artificial joints _____
- Implants _____

Prior chemotherapy

Yes No

If yes, which agents (if known)? _____

When did it start? _____

When did it finish? _____

If currently on chemotherapy, please indicate the date of last cycle _____

Did you receive any bone marrow stimulating drug?

Please specify agent (Neupogen, Epogen) _____

Date of last administration: _____

Prior radiation therapy

Yes No

If yes, which body part? _____

When did it start? _____

When did it finish? _____

Ever had any trauma, fractures, or recent injuries?

Yes No

If yes, please list with approximate date(s) and part of the body.

Mark if you have any of the following (please specify how long you had this problem)

- Heart disease _____
- Hypertension / High Blood Pressure _____
- Stroke _____
- Lung disease _____
Lung cancer Asthma Bronchitis Smoker Yes No How long? _____
- Kidney disease _____
- Liver disease _____
- Reflux / heartburn _____
- Thyroid problems _____
Nodules/inflammation Hypothyroidism Hyperthyroidism

- Sinus problems _____
- Hernia _____
- Skin problems _____
- Multiple myeloma or paraproteinemia _____
- Sickle cell disease _____

Please list your **medications**, and the reason why you take them:

If you are Diabetic, how is your diabetes treated?

- | | | | |
|--------------------|------------------------------|-----------------------------|-----------------|
| Pills? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Type: _____ |
| Insulin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How much: _____ |
| Diet and exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

What is your fasting blood sugar/glucose? _____

Are you having joint problems? Yes No

If yes,

Please specify which joints _____

Please rate the quality of joint pain: Mild Moderate Intense

Are you having bone pain? Yes No

If yes, location? _____

Please rate the quality of bone pain? Mild Moderate Intense

Do you have any known allergies (medication, shellfish or other foods)? Yes No

If yes, please specify _____

Any recent intramuscular injection in the last 2 weeks? Yes No

Please specify body part and if for vaccine therapy, B12 injection, etc. _____

Describe your bowel habits on the scale below:

(Constipation) 1 2 3 4 5 6 7 8 9 10 (Diarrhea)

Are you pregnant? Yes No Last menstrual cycle: _____

