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:
- ☐ Itching
- ☐ Headache
- ☐ Nausea, vomiting
- ☐ Shaking
- ☐ Rash, hives
- ☐ Chills
- ☐ Dizziness
- ☐ Other ____________________

Moderate reaction:
- ☐ Generalized urticaria
- ☐ Severe nasal congestion
- ☐ Marked swelling: eyes, face
- ☐ Dyspnea
- ☐ Bronchospasm / Wheezing
- ☐ Vasovagal response
- ☐ Hypertension / Hypotension
- ☐ Tachycardia / Bradycardia

Severe life-threatening reaction:
- ☐ Laryngeal edema
- ☐ Profound hypotension
- ☐ Convulsions
- ☐ Unresponsiveness
- ☐ Clinically manifest arrhythmias
- ☐ 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:

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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:

____

____

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If you are Diabetic, how is your diabetes treated?

Pills? ☐ Yes ☐ No Type: ______________________________

Insulin? ☐ Yes ☐ No How much: ______________________________

Diet and exercise? ☐ Yes ☐ 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: ______________________________

DO NOT WRITE BELOW THIS LINE

Accession Number: ______________________________

NURSING NOTES:

Blood Glucose: __________________________

IV site: ____ **Infiltration** ☐ Yes ☐ No

Oral contrast administered by: ____ ☐ RN ☐ MA

Dose and Concentration: ____

Intravenous contrast administered **by:** ____ ☐ MD ☐ RN

Dose and Concentration: ____

Notes: ____

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Nurse ____ Signature ______________________________________

Date and time ____

PET TECHNOLOGIST NOTES:

Isotope: _______________ Dose: ________________Post Syringe: _______________Net Dose: ______________

Time Injection: __________ Site of Injection: __________________________________

Infiltration: ☐ Yes ☐ No

Technical Problems? (Please explain)

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Technologist ___________________________________ Signature _____________________________________

Date and time ____