Reason for today’s PET scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When were you diagnosed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If cancer: Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received any treatment for your cancer/condition? Y [ ]  / N [ ]

**THERAPY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Have you had:** |  |  | **Date Last Received** | **Date of Next Treatment** | **Date ENTIRE Course Completed** |
| **SYSTEMIC THERAPY** (chemotherapy, hormonal therapy, Rituxan, interferon, etc.): |  Y [ ]   |  N [ ]  |  |  |  |
| **RADIATION THERAPY** |  Y [ ]   | N [ ]  |  |  |  |
| **OTHER** (ex. ablation, bone marrow transplant, etc.): |  Y [ ]   | N [ ]  |  |  |  |

Have you had any injections to stimulate your bone-marrow to produce more blood cells? (Neupogen, Procrit, Neulasta, Aranesp, etc.) Y [ ]  / N [ ]

If yes, when was your last injection? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY**:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Date Performed** | **What type of procedure** | **What area of the body** |
| RELATING TO YOUR CANCER |  |  |  |
| BIOPSY |  |  |  |
| PORT-A-CATH PLACEMENT |  |  |  |
| OTHER SURGERIES |  |  |  |

# COMPARISON STUDIES:

|  |  |  |  |
| --- | --- | --- | --- |
|  | DATE | BODY PART | FACILITY |
| PET |  |  |  |
| CT |  |  |  |
| MRI |  |  |  |
| BONE SCAN |  |  |  |
| X-RAY |  |  |  |
| OTHER |  |  |  |

 **SELECT THE FOLLOWING IF IT APPLIES TO YOU:**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ] Previous broken bones :  | [ ] Active Hemorrhoids | [ ] Ulcers/GI disease | [ ] GE reflux/heartburn |
| [ ] Arthritis:  | [ ] Feeding or PEG Tube | [ ] Colostomy bag | [ ] Urine Collection Bag |
| [ ] Other metal in the body:  | [ ] Pacemaker | [ ] Smoker For how many years?  |
| [ ] Recent Infections:  | [ ] On oxygen | [ ] Use a wheelchair or walker |

Are you diabetic? Y [ ]  N [ ]  If YES, Last blood sugar: **\_\_\_\_\_** Controlled by (Check one): Diet [ ]  Pills [ ]  Insulin [ ]

List current medications you are taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALES:** Are you pregnant? Y [ ]  N [ ]  ***If you are not sure, contact the technologist immediately!***

 Are you breastfeeding? Y [ ]  N [ ]  When was your last menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MALES:** Any history of prostate problem? Y [ ]  N [ ]  Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any trouble lying on your back with your arms over your head for about 30 minutes? Y [ ]  N [ ]

\* Are you claustrophobic? Y [ ]  N [ ]  If you are, has your doctor prescribed any medication for you to help relax you? Y [ ]  N [ ]

**If Yes to above, do you have a driver to take you to and from the Center after you take your relaxation medication? Y** **[ ]** N**[ ]**

When did you eat last? \_**\_**:\_\_ AM [ ] / PM [ ]  What did you eat / drink (other than water)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When is your follow-up appointment with your doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other doctors you would like to send your PET scan to? (ex. Cancer Doctor, Radiation Doctor, Surgeon, Primary Care Doctor, Other, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient PRINTED NAME Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Email Address