

**REGIONAL RADIOLOGY
360 BARD AVENUE
718-876-2000
PET QUESTIONNAIRE**

Please provide the following information:

Name: _____ Date of Exam _____

Date of Birth _____ Sex M F

Referring Physician _____ Height _____ Weight _____

Reason for Exam _____

Previous Surgery Y N *If yes, please explain*

Date: _____ Type of surgery _____

Date: _____ Type of surgery _____

Date: _____ Type of surgery _____

Date: _____ Type of surgery _____

Radiation Therapy Y N *If yes, please explain*

Date Range: from _____ to _____ Area of body: _____

Date Range: from _____ to _____ Area of body: _____

Date Range: from _____ to _____ Area of body: _____

Chemotherapy: Y N *If yes, please explain*

Date Range: from _____ to _____ Drug(s): _____

Date Range: from _____ to _____ Drug(s): _____

Date Range: from _____ to _____ Drug(s): _____

Diabetic: Y N **Insulin:** Y N **Time of last dose** _____

Do you have:

Colostomy Y N

Ileostomy Y N

Port-a-cath Y N

Drains/open wounds Y N where? _____

Infections Y N where? _____ on antibiotics _____

Pacemaker Y N

Artificial joints Y N where? _____

Implants Y N where? _____

Recent injuries Y N where? _____ when? _____

Arthritis Y N

Thyroid Disease: Y N

Anything to eat/drink today? When and What? _____

For official use only:

DOSE: _____ mCi Inj Time _____ inject site _____ Inj By _____

Glucose _____ mg/dl MRN _____