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Date

Med Rec #

Patient Questionnaire

Name M/F DOB/Age.....

What is the reason having a PET scan?

Any treatment between previous and current PET scan

Do you have any history of cancer? Y N

If yes, what cancer and when was it diagnosed

Any biopsy? Y N

If yes, which area when

Positive or negative

Did you have any treatment for the cancer? Y N

If yes, **Chemotherapy**: start end

Radiation: which area start end.....

Did you have any **Surgery**? Y N

If yes, what surgery when

Did you have bypass surgery or coronary stents? Y N

Any trauma /fall /fracture? Y / N, if yes, when

Any colonoscopy? Y / N, If yes, when Result: cancer +/-

Last Menstruation

Do you smoke? Y.....N.....

Did you have previous PET scan?

Do you bring the **reports** from outside? Y / N

Ht Wt

FDG dose Blood glucose

**THE PATIENTS SHOULD STAY AWAY FROM THE YOUNG CHILDREN AND
PREGNANT WOMEN FOR 12 HOURS AFTER INJECTION.**