Clinical P.E.T. of West County
PATIENT QUESTIONNAIRE

Please fill in the following information as best you can:
Name:____Date of Birth:________________
Height:_____________ Weight:_____________ Age:__________ Sex:_______
Is there a possibility you may be pregnant? No_____ Yes_____ Last Menstrual Period? _______
Are you diabetic? No_______ Yes_______ If yes, what is your daily insulin dose? ________units
What medications do you take at home?
____
____
____
____
If you have allergies to any medications, please list: ____

Did you bring any radiology films with you? No_______ Yes_______
If not, have you had a CT_______ or an MRI_______ before? If so, when and where were they done?____
Have you ever had a PET scan before? No_______ Yes_______ If so, when and where did you have it?
____
Referring physician:____Office number:___________
If you have a known tumor, the following applies to you:
Where is your tumor?____Diagnosed when?_______________
Have you ever had surgery for your tumor? No_______ Yes_______ If yes, when?_________________
Have you ever had chemotherapy for your tumor? No_______Yes_______ If yes, when?___________
Is your chemotherapy completed? No_______ Yes_______
Have you had radiation therapy for your tumor? No_______Yes_______If yes, when?_______________
What treatment have you had since your last PET scan (if applicable)?__________________________
Have you had any new symptoms since your last PET scan? If so, please list:____________________
____

What are your CEA/PSA or other tumor marker levels?__________________________Date___________
Have you ever been diagnosed with any other tumor? No_______ Yes_______
Do you have a colostomy? No_______ Yes_______
Do you have trouble completely emptying your bladder? No_______ Yes_______

SIGNATURE____DATE____________