PARTNERS IMAGING CENTERS

*For Partners Use*

MRN #

# CT & PET/CT Patient History Questionnaire

Patient Name

Ordering Physician

Exam

1. Please list the reason your doctor has ordered this exam.

2. Please list the type(s) and approximate date(s) of any surgery you have had.

3. Have you ever had cancer? Yes ☐ No ☐

If yes, what type of cancer? _____

4. Have you ever had Radiation Therapy treatments? Yes ☐ No ☐ When? _____

5. Have you ever had Chemotherapy treatments? Yes ☐ No ☐ When? _____

6. Please list the date and location of any recent X-Rays, CT, Ultrasound, Nuclear Medicine, or MRI scan you have had.

7. Do you have, or have you ever had, any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Asthma | Yes ☐ | No ☐ | Hay Fever | Yes ☐ | No ☐ |
| Lung Disease | Yes ☐ | No ☐ | Heart Disease | Yes ☐ | No ☐ |
| Thyroid Disease | Yes ☐ | No ☐ | Kidney Disease | Yes ☐ | No ☐ |
| Sickle Cell Disease | Yes ☐ | No ☐ | Multiple Myeloma | Yes ☐ | No ☐ |
| Pheochromocytoma | Yes ☐ | No ☐ | Diabetes | Yes ☐ | No ☐ |
| | | | Oral Insulin Diet | Yes ☐ | No ☐ |

8. Are you allergic to any of the following:

| | | |
|---|---|---|
| Medication | Yes ☐ | No ☐ |
| X-Ray Dye (iodine) | Yes ☐ | No ☐ |

Height _____

Weight _____

9. Infections? Yes ☐ No ☐ If Yes, detail: _____

**Patient / Guardian Signature**

**Date**

TECHNOLOGIST NOTES

PET DOSE _____ mCi 18 FDG @ time _____

INJ Site _____ Glucose _____mg/dL