Nuclear Medicine and PET/CT Patient Questionnaire

Orange County Diagnostics

Laguna Woods, California

Study Date: _____ Patient MRN: _____

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Gender: ☐ Male ☐ Female

What is the last time you had something to eat? _____

Are you diabetic? ☐ No ☐ Yes If so: On Insulin? _____ On Oral Diabetic Meds? _____

Are you pregnant or possibly pregnant? ☐ No ☐ Yes If so, please inform the staff & technologist immediately!

Current Symptoms

What is the reason for your study today?
(Please list any current symptoms you are having)

How long have you had these symptoms?

_____

Medications

Please list any medications you are currently taking:

Any medication allergies?

☐ No (or Unknown) ☐ Yes: _____

History

Please list any types of CANCER and when diagnosed:	Please list any prior CHEMOTHERAPY and the dates:
Please list any prior SURGERIES and the dates:	Please list any prior RADIATION THERAPY and the dates:
Recent Trauma or Injuries?	

Prior Tests

Type:	What Body Part?	When?	Where?
X-Ray			
MRI Scan			
CT Scan			
Ultrasound			
Nuclear Medicine			
PET or PET/CT			
Other: _____			