PET/CT Medical History

Date:_____

Name:_____ **Weight:**_____ **Height:**_____

1	**Follow up Appointment Scheduled?**	Yes ❑	No ❑	**Date: _____**
2	**Have ever been diagnosed with cancer?**	Yes ❑	No ❑	Type: _____ Location: _____ Date: _____
	Surgery for cancer?	Yes ❑	No ❑	Area of Body: _____ Date**:** _____
	Biopsy?	Yes ❑	No ❑	Area of Body: _____Date: _____
3	Have you ever had **Chemotherapy**?	Yes ❑	No ❑	**Most Recent Date: _____**
	Have you received injections of **Epogen (Procrit), Neulasta®, or Neuprogen®?**	Yes ❑	No ❑	Date:_____
4	Have you ever had **Radiation Therapy**?	**Yes ❑**	**No ❑**	**Most Recent Date: _____** **Area of body**: _____
5	Any recent injury?	Yes ❑	No ❑	Area of body
6	Implants or Artificial Joints	Yes ❑ Yes ❑ Yes ❑ Yes ❑ Yes ❑	No ❑ No ❑ No ❑ No ❑ No ❑	Pacemaker PICC or Port? (Location)_____ Tracheotomy Ileostomy/Colostomy Artificial Joints_____ Other:
7	**Anything to eat or drink today?**	**Yes ❑**	**No ❑**	**If yes, what and time:**

Endocrine/Hyperplastic, Inflammation/Physiologic and Artifacts

1	**Do you have diabetes?**	Yes ❑	No ❑	**Insulin** ❑ Name_____ **Pill** ❑ Name _____
2	Do have Arthritis?	Yes ❑	No ❑	Location(s):
3	Any infection in the last 2-3 weeks?	Yes ❑	No ❑	If yes, detail:
4	Allergies to any medications?	Yes ❑	No ❑	**Name:**
5	History of TB, histoplasmosis, Sarcoid	Yes ❑	No ❑	If yes, detail:
6	**X-ray** studies with **Oral** contrast past 2 weeks?	Yes ❑	No ❑	When:

If you are a woman between the ages of 10 - 55 years of age please complete questions below

Are you pregnant or possibility of pregnancy Are you breast-feeding?	Yes ❑ Yes ❑	No ❑ No ❑	Last menstrual period:

I do not believe that I am pregnant and/or breast-feeding.

Patient signature:_____**Date:**_____