Patient sticker

PET/CT Bone Screening

Patient name: _____

Last time of food or drink (*including gum or mints*): _____

□ Y □ N **Have you ever been diagnosed with cancer, past or present?**
Which type: _____
What treatment: _____

□ Y □ N **List <u>any</u> surgeries, <u>recent</u> infections, traumas, factures, or arthritis:**
Location/date: _____

□ Y □ N **Are you diabetic?**
If yes, please list medications: _____

□ Y □ N **Are you pregnant or currently nursing?**

□ Y □ N **Have you ever had chemotherapy?**
If yes, when: _____

□ Y □ N **Have you had radiation therapy?**
If yes, when: _____
What body part: _____

□ Y □ N **Have you had any recent dental work?**
If yes, when: _____

□ Y □ N **Have you had any recent lab work?**
If yes, indicate where: _____

□ Y □ N **Are you allergic to iodine contrast?**

□ Y □ N **Are you experiencing bone pain?**
If yes, where: _____

□ Y □ N **Have you had any other CT, MRI, PET or Bone scans related to today's exam?**
If yes, list which scan(s): _____

Do you have any of the following medical conditions?

□ Y □ N Asthma
□ Y □ N Heart disease or hypertension
□ Y □ N Decreased kidney function or dialysis
□ Y □ N Sickle cell disease
□ Y □ N Liver disease

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY. Please do not write below this line.

Scan time: _____ **Weight:** _____

Dose Label

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