Patient sticker

Neurological PET-CT Screening

Patient name: ______________________________

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

□ Y □ N **Do you have any history of cancer?**
If yes, which type? ______________________________

□ Y □ N **Do you have any history of neurological disorders or brain trauma?**
If yes, which type (list neuro medications)? ______________________________
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□ Y □ N **Are you diabetic?**
When were your last diabetic medications taken? ______________________________

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

□ Y □ N **Have you had any brain surgeries?**
If yes, when and where? ______________________________

□ Y □ N **Have you had any related exams? (CT, MRI, PET)**
If yes, which exam(s)? ______________________________

□ Y □ N **Have you had any chemotherapy or radiation treatment?**
If yes, when? ______________________________

Signature: ______________________________ **Date:** ________________

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

Scan time: ______________________________ **Weight:** ________________

Blood Glucose level: ________________