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)? ______________________________________

☐ 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: ___________________