LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C.

PET SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: DATE:

DATE OF APPOINTMENT: / / DATE OF BIRTH: / / AGE:

REFERRING PHYSICIAN: PHONE #:

How much do you weigh? lbs.

Are you pregnant? ☐YES ☐NO Are you breast feeding? ☐YES ☐NO

Any nuclear medicine studies within 48 hours? ☐YES ☐NO Exam:

Previous MR studies? ☐YES ☐NO If yes, date of exam: / /

Previous CT studies? ☐YES ☐NO If yes, date of exam: / /

Prior PET scan? ☐YES ☐NO If yes, date of exam: / /

Where: Did you bring any outside films/reports with you? ☐YES ☐NO

Did you bring any outside films/reports with you? ☐YES ☐NO

Any history of Melanoma? ☐YES ☐NO Area on body: Date treated:

Are you a diabetic? ☐YES ☐NO If YES,

Oral Meds ☐YES ☐NO Insulin ☐YES ☐NO

Diet controlled ☐YES ☐NO

Are you a smoker? ☐YES ☐NO If you quit, how long ago:

COMPLETED BY TECHNOLOGIST

Do you have a clearly stated written referral? ☐YES ☐NO

What is the clinical question?

Does the study make sense in light of clinical info provided? ☐YES ☐NO

NPO since: Confirm patients name:

Does the patient have pain? ☐YES ☐NO Where?

History of Cancer? ☐YES ☐NO What kind?

Chemotherapy? ☐YES ☐NO Date of last treatment?

Radiation therapy? ☐YES ☐NO Date of last treatment?

Has the patient had surgery? ☐YES ☐NO When?

What kind?

Have you explained exam to patient? ☐YES ☐NO

SCREENED BY: SCREENED WITH:

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature: Date: / /