Stockton MRI & Molecular Imaging Medical Center

2320 North California Street, Stockton, CA 95204. tel: (209) 466-2000, fax: (209) 466-2600

Tracking # 10_________
Date:

QUESTIONNAIRE FOR PET-CT SCAN PATIENTS

YOUR INFORMATION

Name:____ Date of Birth _________________

Height _________________Weight_______________Are you diabetic?_______________________

When was the last time you had something to eat?______________________________________

WHY has your doctor ordered this scan for you? ____

Are you pregnant? _________________________ Signature:______________________________
(Please inform the technologist if you are pregnant.)

YOUR CANCER AND TREATMENT HISTORY

Please list what type(s) of **CANCER** you have and about **WHEN** the cancer was diagnosed:	Please list your prior **SURGERIES** (what parts of your body), and about **WHEN** was the surgery:
When was your last **CHEMOTHERAPY**?	When was your last **RADIATION** therapy? What part(s) of your body received radiation?

PREVIOUS SCANS

Have you ever had any of the following types of tests?

	What part of you?	**When?**	**Where?**
□ **X-Rays**			
□ **MRI**			
□ **CT scan**			
□ **Ultrasound**			
□ **Nuclear Medicine**			
□ **PET scan**			