NUCLEAR MEDICINE/ PET SCAN PATIENTS

Are you diabetic? If you take diabetes medications, when was the last time?

☐ No
☐ Yes ____

When is the last time you have eaten **(includes candy/gum)**? __________________________________

Are you claustrophobic?
☐ No
☐ Yes

Have you ever had surgery?

☐ No
☐ Yes ____

Have you had a fracture (broken bone) in the last 6 months?

☐ No
☐ Yes ____

Are you on chemotherapy? If so, when was your last treatment?

☐ No
☐ Yes ____

Have you had a Nuclear Medicine or PET exam before?

☐ No
☐ Yes (when and where) ____

Have you received the vaccine for COVID 19?

☐ No
☐ Yes → Date of most recent vaccine _______________ Please circle: Left Arm or Right Arm

____ ___________________________
Print Patient Name DOB

____ ___________________________
Signature Date

Updated 7/11/2024