QUESTIONNAIRE FOR BRAIN PET SCAN PROCESS

PATIENT FULL NAME _____
Last Name **Middle Name** **Name (s)**

SEX : F M	AGE: _____	BIRTHDATE: _____/_____/_____ **MM DD YY**	WEIGHT: _____	**Mark with an "X" the weight unit:** KILOS	POUNDS

ADDRESS:_____
Street Name and Number **City and State** **ZIP CODE**

E-MAIL (S) :_____

PHONE NUMBER (1):_____ PHONE NUMBER (2):_____

NAME AND SPECIALTY OF THE REQUESTING PHYSICIAN :

ATTENDING PHYSICIAN PHONE NUMBER _____ ATTENDING PHYSICIAN E-MAIL ADDRESS _____

Medical Diagnosis (If you don't know, please ask your doctor):

Reason of the Study (If you don't know, please ask your doctor)

Since when you have being suffering from this disease or symptoms?

What type of medicines you have taken or are taking for the disease?

Have you received radiation therapy? **YES NO**
If your answer is **Yes** please indicate date of your last session:
_____/_____/_____
Day Month Year

Have you received of chemotherapy? **YES NO**
If your answer is **Yes** please indicate date of your last session:
_____/_____/_____
Day Month Year

Date and type of the last surgery (Includes biopsies, tattoos, ear expansions, removal of any dental piece, or a wound that required stitches:

Type of Surgery:_____ _____/_____/_____
Day Month Year

Does the patient suffer from diabetes? **YES NO** If your answer is **Yes** please indicate name of the medication that is being use to control it:
_____

If in fact you suffer from diabetes, please indicate your glucose levels from the last 5 days:

Day 1: _____/ **Day 2:**_____/ **Day 3:** _____/ **Day 4:** _____/ **Day 5:** _____/

Does the patient understands and can follow instructions?	YES	NO	Does the patient need a wheelchair?	YES	NO
Does the patient have involuntary movements? If your answer is **Yes**; you need to know that the Anesthesiology Service will be needed and that it has an extra cost	YES	NO	Do you require stretcher?	YES	NO
Is the patient left-handed?	YES	NO	Is the patient in bed?	YES	NO
Does the patient require supplemental oxygen?	YES	NO	Is the patient hospitalized?	YES	NO
Can the patient move around by him or herself?	YES	NO	Are you pregnant or breastfeeding?	YES	NO
Does the patient use any other assistance device to move around? Which is: _____	YES	NO	Do you require Anesthesiologist service for the study? *It is recommended for patients who are in a lot of pain or are extremely nervous or claustrophobic and it is impossible for them to be still for 20 minutes which the time that it takes to capture the images* If your answer is **Yes**, you need to know that the cost of the service of Anesthesiology is extra from the BRAIN PET SCAN	YES	NO

Have you previously had a study done at Scantibodies? YES | NO Which one? _____

PATIENT SIGNATURE **DATE** _____/_____/_____
Day Month Year

Please send all documents to the following e-mail: citas@imagenologiayterapia.com