QUESTIONNAIRE TO START FULL BODY PET-CT SCAN PROCESS

PATIENT GENERAL INFORMATION

PATIENT FULL NAME: _____

Last Name **First Name** **Suffix**

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

ADDRESS:_____

NAME OF THE STREET AND NUMBER **CITY AND STATE** **ZIP CODE**

EMAIL:_____

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

QUESTIONS AREA | PLEASE ANSWER EACH AND EVERY ONE OF THEM

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

NAME OF THE REQUESTING PHYSICIAN FOR THE PET-CT SCAN STUDY:

ATTENDING PHYSICIAN PHONE NUMBER:

ATTENDING PHYSICIAN EMAIL 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):

Have you received **Radiation Therapy**? **YES** **NO**

If **Yes** please indicate date of your last session: _____/_____/_____ Day Month Year

In which part of the body did you receive radiation therapy?

_____

Have you received of **Chemotherapy**? **YES** **NO**

If **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 surgery: _____ _____/_____/_____

Day **Month** **Year**

Does the patient suffer from diabetes? **YES** **NO**

If your answer is **Yes** please indicate the name of the medication that is being used to treat 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:** _____/

Can you move around by yourself?	YES	NO	Are you hospitalized?	YES	NO
Do you use any other assistance device to move around?	YES	NO	Do you require supplemental oxygen?	YES	NO
Which one:_____			**In Woman Only.** Are you pregnant or breastfeeding?	YES	NO

Do you think you will need Anesthesia Service for the study? **NOTE:** *It is only necessary for small children and patients who are in a lot of pain or are extremely nervous, claustrophobic or have involuntary movements* YES NO

If your answer is Yes, you need to know that the cost of the service of Anesthesiology is extra from the PET-CT SCAN

IN CASE YOU REQUIRE INVOICE, PLEASE FILL IN THE FOLLOWING INFORMATION

FULL NAME OF WHO REQUIRES THE INVOICE

_____

Last Name **Middle Name** **Name (s)**

ADDRESS:_____

Street and Number **City and State** **ZIP Code**

TAX ID Number: _____

E-MAIL: _____

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

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