



Name: _____ Date: _____

Date of Birth: _____ Height: _____ Weight: _____

Referring Physician: _____

Primary Diagnosis: _____

Are you diabetic? Yes No Blood Sugar Level: _____

When did you last take your insulin? Time: _____ Dose: _____ Type: _____

When was the last time you ate? _____ Normal Fasting Blood Sugar 60-110 mg/dl 2 Hour pc<140 mg/dl

Did you take a sedative or pain medication before coming today? Yes No

If yes, what did you take? _____

Are you allergic to valium? Yes No

Have you had a previous PET Scan Yes No When and where? _____

Have you had a previous CT Scan? Yes No When and where? _____

Have you had a previous MRI Scan? Yes No When and where? _____

Have you had a recent mammogram? Yes No and/or Breast tissue biopsy Yes No

When and where? _____

Was it positive, abnormal or suspicious? Yes No

Previous surgery? Yes No When and where? _____

Have you had chemotherapy? Yes No

Last treatment? _____ When did you start? _____ How often? _____

Have you had radiation therapy? Yes No

Last treatment? _____ When did you start? _____ How often? _____

Dose: _____ Tech: _____

Time of Assay: _____ Time of Injection: _____

Time of Imaging Post Injection: _____ minutes

Residual Activity: _____ @Time: _____

Injection Site: _____ Neck Brace: Yes No

