Billings Clinic

# PET Patient History Form

***Please compete this form and bring it to your appointment.***

DIAGNOSIS:_____
DATE OF DIAGNOSIS:_____

Surgery:_____Date:_____ Surgery _____Date:_____

Surgery _____Date:_____ Surgery:_____Date_____

Surgery _____Date:_____ Surgery _____Date:_____

Please List all Medications:_____

_____

Recent Dental Work or Problem (Location and date):_____

Locations of any Metal Implants, Pacemakers, Extreme Dental Devices, Colostomy,

Etc:_____

Location of Injection in last 2 weeks or flu shot within last 3 months:_____

Are you currently on or received in the past injections for stimulating Blood Cell formation (*procrit/ neupogen /neulasta)?*
*(Y/N) Date of injection:*_____

*Tobacco use (Y/N) Packs per week?___ Years of use__ Type of Tobacco_____*

PREVIOUS SCANS
PET Scan Location_____date:_____ CT Scan Location_____date:_____

MRI Scan Location_____date:_____

Have you had radiation therapy? (Y/N) Have you had chemotherapy? (Y/N)

When:_____ When:_____

Have you had any upper respiratory infections within the past month? (Y/N)

| Patient sticker |
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