



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)? _____

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