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**SM-UCLA PET/CT CENTER PATIENT INFORMATION SHEET**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician(s): \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex:  M  F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1. If you know the reason your doctor ordered this PET/CT study please indicate here:

2. Have you had a CT scan recently?  Yes  No  
If yes, on what date? \_\_\_\_\_

If yes, were you given IV contrast?  Yes  No

3. Have you had previous surgery or biopsy?  Yes  No  
If yes, please list dates and briefly describe what was done?

4. Previous or ongoing radiation therapy?  Yes  No  
If yes, please list start and end dates of most recent radiation treatments.

5. Previous or ongoing chemotherapy?  Yes  No  
If yes, please list start and end dates of most recent chemotherapy treatments.

6. Do you have diabetes?  Yes  No  
If yes, do you take Insulin?  Yes - Time of last insulin dose: \_\_\_\_\_  No

Do you take Glucophage or Metformin?  Yes - Time of last dose: \_\_\_\_\_  No

7. Do you receive any treatment by injection into the skin or muscle?  Yes  No  
If yes, specify the location of injection site(s) and how recent they were given.

Site \_\_\_\_\_ Time \_\_\_\_\_

8. Do you have any of the following:

Drains/Open Wounds  Yes  No If yes, location \_\_\_\_\_  
Infections  Yes  No If yes, location \_\_\_\_\_  
Recent Injuries  Yes  No If yes, location \_\_\_\_\_

9. Other major medical illnesses or medical problems (please list here):

10. Have you had any food or beverages, candy (except water or medications) within 6 hours of this scan?  
 Yes If yes, how many hours ago? \_\_\_\_\_ What \_\_\_\_\_  No