PET/CT IMAGING
OF BERKELEY
2855 Telegraph Ave., Suite 100, Berkeley, CA 94705
AMERICAN COLLEGE OF RADIOLOGY ACCREDITED PET AND CT FACILITY

New Patient Questionnaire

Name: _____

Date: _____ Age: _____ Weight: _____

What was the time of your last meal? _____ AM / PM (circle one)

What was the time of your last beverage? _____ AM / PM (circle one)

Have you had a COVID-19 vaccination? □ Yes □ No

If YES, in which arm was the vaccination administered? □ Left □ Right

Do you currently live in a skilled nursing facility? □ Yes □ No

Why did your doctor request a PET scan?

_____

_____

_____

If applicable, please provide dates (month & year) for the questions below:

When was the problem discovered? _____

Date and results of recent biopsies: _____

Date of most recent dental work: _____

Dates and types of **ANY RECENT** surgeries: _____

Dates of **MOST RECENT** radiation therapy: _____

Dates of **MOST RECENT** chemotherapy: _____

Date and results of last PET/CT scan
or other nuclear medicine study: _____

Date and results of last CT scan: _____

Date of recent BONE scan: _____

Date and results of last MRI scan: _____