Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122

PET/CT QUESTIONNAIRE/AUTHORIZATION

(office use)

Name: _____ Date of Exam: _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

1. **Why are you having this exam?** _____

2. **Sex assigned at birth:**
   ☐ Female ☐ Male ☐ Unknown ☐ Not Recorded on Birth Certificate ☐ Choose Not to Disclose
   ☐ Gender non-confirming ☐ Uncertain ☐ Intersex

   If female, is there any possibility that you are pregnant? ☐Yes ☐No
   Are you breastfeeding? ☐Yes ☐No
   When was your last menstrual cycle? _____

3. **What is your gender identity?**
   ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Other ☐ Choose Not to Disclose
   ☐ Gender non-confirming ☐ Something Else ☐ Nonbinary

4. **Have you ever had a biopsy or surgery outside of NYP, Cornell or Columbia?** ☐Yes ☐No
   If yes, please list all surgical procedures and dates: _____
   _____

5. **Do you have a history of chemotherapy?** ☐Yes ☐No
   If yes, are you currently receiving chemotherapy? ☐Yes ☐No
   What was the date of the last cycle for chemotherapy? _____

6. **Have you had any bone stimulating drug (Neupogen/Epogen)?** ☐Yes ☐No
   If yes, what was the last date you took the drug: _____

7. **Have you had any radiation therapy?** ☐Yes ☐No
   If yes, specify the body part: _____
   When did radiation start? _____
   When did radiation end? _____

8. **Do you have history of diabetes?** ☐Yes ☐No
   If so, are you on any medications? ☐Yes ☐No
   Do you take insulin? ☐Yes ☐No
   What is your fasting blood sugar/glucose? _____

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9. **Have you had a recent intramuscular injection in the past two weeks?** ☐Yes ☐No
   Site of injection: _____

10. **Do you have an allergy to latex?** ☐Yes ☐No

11. **Do you have a history of kidney disease, kidney failure, transplant kidney tumor and/or kidney surgery/interventional procedure of any kind?** ☐Yes ☐No

12. **Do you have claustrophobia?** ☐Yes ☐No

    Do you plan on taking medication for claustrophobia before today's exam? ☐Yes ☐No

    If you are taking an oral anti-anxiety medication for claustrophobia, we recommend having a visitor accompany you to your appointment or arrange for transportation home. Our practice recommends this out of an abundance of caution and concern for your safety as potential side effects of these medications may affect your ability to drive or navigate public transportation.

I authorize Weill Cornell Imaging at NewYork-Presbyterian, its physicians, and other staff to perform the prescribed examination. I have read and understand the above information.

Signature of Patient (Parent or Guardian):

_____ Date: _____

Front Desk Staff:_____ Signature: _____

Technologist: _____ Signature: _____

Nurse: _____ Signature: _____