PET/CT Imaging Center
of Northwest Florida

PATIENT INFORMATION SHEET

Patient Name: _____ Date: _____

Birth Date: _____ Social Security Number: _____- _____-_____

Phone Number(s): _____

Address: _____ Lot/Apt: _____

City: _____ State: _____ Zip Code: _____

Please check any of the following illnesses or conditions you have or have had in the past:

_____ AIDS/HIV
_____ Arthritis
_____ Claustrophobia
_____ Dementia
_____ Epilepsy
_____ Hepatitis
_____ Latex Allergy
_____ Shingles
_____ Tuberculosis

Have you eaten or had anything to drink besides water today? _____yes _____no

Are you currently taking insulin or any diabetic medications? _____ yes _____ no

If yes, have you taken either today? _____yes _____no

Have you been diagnosed with cancer? _____yes _____no

If yes, have you had chemotherapy? _____yes _____no

" " " " " radation? _____yes _____no

Are you pregnant and or breastfeeding?: _____ yes _____ no

To the best of my knowledge, all of the information provided above is correct:

_____
Signature of patient, parent, power of attorney, or guardian