



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:

- | | |
|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | |

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 radiation? 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