

**Questionnaire**

**Patient ID:** \_\_\_\_\_

**Patient's Initials:** \_\_\_\_\_

The following is a medical history and general patient information questionnaire.

1. Have you ever received chemotherapy?  
**YES / NO** (circle one)
  - a. If **YES**, when was your most recent treatment? \_\_\_\_\_years \_\_\_\_\_months
  - b. If **YES**, what type(s) of chemotherapy have you received? \_\_\_\_\_  
\_\_\_\_\_
  
2. Have you ever had a stroke?  
**YES / NO** (circle one)
  
3. Do you have diabetes?  
**YES / NO** (circle one)
  - a. If **YES**, are you currently taking insulin?  
**YES / NO** (circle one)
  - b. Is your diabetes poorly controlled (blood sugars routinely above 200)?  
**YES / NO** (circle one)
  
4. Do you have hypertension (high blood pressure)?  
**YES / NO** (circle one)
  - a. If **YES**, are you currently being treated for hypertension?  
**YES / NO** (circle one)
  - b. If **YES**, what medication(s) are you taking for hypertension? \_\_\_\_\_  
\_\_\_\_\_
  
5. What is the highest level of education you have achieved? (circle one)  
**0-4 Years | 5-8 Years | 9-12 Years or HS Diploma | College or Higher**
  
6. What medications are you currently taking? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
7. What is (or was) your primary occupation? \_\_\_\_\_  
\_\_\_\_\_
  
8. When is your birthday? \_\_\_/\_\_\_/\_\_\_\_\_ (month/day/year)
  
9. What is your ethnicity? (circle one)  
**Caucasian | African American | Latino/Hispanic | Other | Not Specified**
  
10. Gender?  
**Male / Female** (circle one)
  
11. Are you right- or left-handed?  
**Left / Right** (circle one)

12. Do you have a brain tumor?  
**YES / NO** (circle one)
13. Do you have cancer that has spread to your head or neck?  
**YES / NO** (circle one)
14. Have you ever received radiation treatment to your head or neck?  
**YES / NO** (circle one)
15. Do you have a history of drug abuse?  
**YES / NO** (circle one)
16. Do you have a history of alcohol abuse?  
**YES / NO** (circle one)
17. Do you have leukemia?  
**YES / NO** (circle one)
18. Do you have a history of significant head trauma?  
**YES / NO** (circle one)
19. Do you have kidney failure?  
**YES / NO** (circle one)
20. Do you have severe chronic obstructive pulmonary disease (COPD)?  
**YES / NO** (circle one)
21. Do you have severe cardiac disease?  
**YES / NO** (circle one)
22. Do you have an immunocompromised disease such as common variable immunodeficiency, selective IgA deficiency, or HIV?  
**YES / NO** (circle one)
23. Do you have or have you ever had cancer?  
**YES / NO** (circle one): If yes please list type and whether you have cancer currently or are in remission \_\_\_\_\_

**Below this line to be filled out by administrative personnel only:** (please enter information here not entered in the acquisition computer):

- Patient's Height: \_\_\_\_\_
- Patient's Weight: \_\_\_\_\_
- Net Dosage used: \_\_\_\_\_ mCi
- Dose injection time: \_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_
- Acquisition Time (**start** of brain scan): \_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_
- Acquisition Time (**length** of brain scan): \_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_
- Sedative used? \_\_\_\_\_
- Scanner type:\_\_\_\_\_
- Reconstruction algorithm\_\_\_\_\_
- Attenuation type: (CT, gadolinium or calculated)\_\_\_\_\_
- 2D or 3D PET acquisition? \_\_\_\_\_