PET/CT FDG Brain-Neuro Questionnaire

PET/CT.POL.002 Effective Date: February 2011

Patient Name: _____ **Today's Date:** _____

☐**Female** ☐**Male** **MRN#**_____ **Age:**_____

What symptoms are you having? _____

If none, do you know why your doctor ordered this exam? _____

Has your doctor told you that he suspects you may have Alzheimer's? ☐Yes ☐No ☐Possibly ☐Not sure what doctor thinks

Has your doctor told you that you have MCI (mild cognitive impairment), but not yet Alzheimer's? ☐Yes ☐No ☐Not sure

Does your doctor suspect dementia, but is unsure if it is Alzheimer's? ☐Yes ☐No ☐Not sure

Please indicate if you have or have had any of the following:

Memory Loss ☐Yes ☐No

*How long have you had memory loss? _____

* Would you consider your memory loss to be: ☐Mild ☐ Moderate ☐ Severe

* Has your memory loss progressed: ☐Slowly ☐Fast ☐ Not much change over time

*Difficulty remembering where you are? ☐Frequently ☐Sometimes ☐Almost never

*Difficulty remembering names or finding words? ☐Frequently ☐Sometimes ☐Almost never

*Difficulty remembering the date? ☐Frequently ☐Sometimes ☐Almost never

*Confusion ☐Frequently ☐Sometimes ☐Almost never

Do you shower, dress, & cook on your own? ☐ Yes ☐ No, I have a helper for those things

Do you manage your own finances? ☐ Yes ☐ No, I have a helper for that

Do you still drive a car on your own? ☐ Yes ☐ No

Do you lose things frequently? ☐Yes ☐No

Have you ever had a stroke? ☐Yes ☐No

History of TIA (transient ischemic attack)? ☐Yes ☐No

Parkinson's disease ☐Yes ☐No

Numbness ☐Yes ☐No If yes, to what part of the body? _____ ☐Left ☐Right

Localized Weakness ☐Yes ☐No If yes, to what part of the body? _____ ☐Left ☐Right

Paralysis ☐Yes ☐No If yes, to what part of the body? _____ ☐Left ☐Right

Slurred Speech ☐Yes ☐No

Loss of Balance ☐Yes ☐No

Difficulty Walking ☐Yes ☐No

Do you have a history of cancer? ☐Yes ☐No If yes, what type? _____

If yes, has cancer spread to other areas in body? ☐Yes ☐No If yes, to where? _____

Radiation treatment? ☐Yes ☐No ☐Not applicable If yes, date of last treatment? _____To what body part?____

Chemotherapy? ☐Yes ☐No ☐Not applicable If yes, date of last treatment: _____