Newport Heart A MEDICAL GROUP, INC.

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Cardiac Positron Emission Tomography

(PET Scan)

Patient Information and Instructions

CAREFULLY READ AND FOLLOW ALL INSTRUCTIONS; THEY ARE CRUCIAL FOR ACCURATE RESULTS

1. **NO** food 2 hours prior to the test.
2. **NO** caffeine 24 hours prior to the test. (This includes tea, decaffeinated products, chocolate and soda.
3. **NO** smoking 2 hours prior to the test.
4. Wear comfortable clothing (i.e. shorts, t-shirt, jogging suit, etc.)
5. Females **MUST** wear two piece clothing. **NO** dresses or jumpsuits.
6. **NO** body lotion on chest area 1 day prior to the test.
7. Inform the technician on the day of the exam if you have Glaucoma, Asthma, or Diabetes.
8. **Have a list of your medications.**

Information:

1. **You must bring a snack with you (i.e. juice, bagel, muffin, etc.)**
2. Please be prepared to be in the office for at least 45 minutes.
3. Family members are welcome to come; however they will have to wait in the waiting room.
4. Please do not discontinue any medication, unless the physician instructs you otherwise.

PLEASE COMPLETE THE ATTACHED QUESTIONNAIRE AND BRING IT WITH YOU PRIOR TO YOUR APPOINTMENT

Newport Heart Medical Group

Nuclear Cardiology Patient Information

Patient Name:_____ Date of Birh:_____

Referring Physician:_____

Is this test for a pre-operative evaluation? (Yes) or (No)

If yes, what type of surgery?_____

Who is the surgeon?_____

CLINICAL INFORMATION:

Height:_____ Weight: _____ Age: _____ Breast Cup Size (Females):_____

DO YOU HAVE:

Diabetes? (Yes) or (No)

High Blood Pressure? (Yes) or (No)

High Cholesterol? (Yes) or (No) HDL? (Yes) or (No) LDL? (Yes) or (No)

History of Coronary Artery Disease? (Yes) or (No)

History of Asthma? (Yes) or (No)

Smoking History?_____ Did you Quit? When?_____

Family history of heart disease?_____

HAVE YOU HAD:

Past Heart Attack? (Yes) or (No) If so, When?_____

Recent Chest Pain? (Yes) or (No)

History of congestive heart failure? (Yes) or (No)

Past nuclear test? (Yes) or (No) If so, when?_____ Where? _____

Past heart catheterization? (Yes) or (No) If so, when? _____ Where? _____

Past angioplasty or stent? (Yes) or (No) If so, when? _____ Where? _____

Bypass surgery? (Yes) or (No) If so, when? _____ Where? _____

Please fill this questionnaire out and bring it with you on the day of your nuclear test. Thank you.