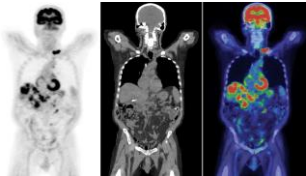


Before the examination of SCANNER, please answer carefully to the following questions :

Surname : Name : Date of birth : / / Weight :Kg Height :

Have you any problem of allergy ? YES NO

Had you a particular reaction during a radiologic examination ? YES NO



Did you spend a scintigraphy or Petscan There less than 72 hours ? YES NO



Have you a treatment in progress (Blocking beta, thyroid, inflammatory, glaucoma) ? YES NO

Are you diabetic ? YES NO

If yes, do you take a treatment using biguanids (Glucophage, Stagid, Metformine, or a générique...) YES NO



Have you a pacemaker or an implanted automatic defibrillator ? YES NO

Have you a Heart, lung or renal disease ? YES NO



Have you a kidney failure or a myeloma ? YES NO



Gentleman, Have you a prostate adenoma ? YES NO



Ladies, Are you pregnant or likely to be ? YES NO Are you breast-feeding ? YES NO

Have you contracted covid 19 ? YES NO If yes, on what date your test was positive ?

In the past 48 hours have you had any of the following symptoms :

- Cough ? YES NO
- Body aches YES NO
- Fever (chills, sweat) YES NO
- Difficulty breathing ? YES NO
- Loss of taste or smell ? YES NO
- Diarrhea YES NO
Have you had Covid cases around you ? YES NO



Informations that seems significant to be communicated and serous illness (Hepatitis C, HIV, cancer) or previous surgical intervention :

I declare to have been informed of various details and risks related to the examination. I give my consent for my personal data to be archived and transmitted to the medical profession (medical specialist, CPR, attending physician...)

Done in Grasse, on / / Signature :