

**H.O.P.E. IMAGING
PATIENT INFORMATION SHEET**

NAME _____ DOB _____ XRAY# _____ DOS _____

ARE YOU DIABETIC? YES _____ NO _____

IF YES, HOW IS YOUR CONDITION CONTROLLED?

DIET _____ ORAL MEDICATION _____ INSULIN INJECTION _____

DID YOU FOLLOW THE DIET RESTRICTIONS GIVEN? YES _____ NO _____

WHAT IS THE REASON THAT YOUR DOCTOR ORDERED THIS TEST? _____

PREVIOUS SURGERIES, AND DATES THEY WERE PERFORMED? _____

PREVIOUS BIOPSIES, DATES DONE & AREAS BIOPSIED? _____

RECENT INFECTIONS/INFLAMMATIONS OR ANTIBIOTIC USE WITHIN THE LAST 2 MONTHS

TYPE/LOCATION OF INFECTION _____ LAST DOSE TAKEN _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY/ANY OTHER MAJOR ILLNESS OR CANCER?

DATE OF LAST CHEMOTHERAPY _____ NONE _____

DATE OF LAST RADIATION THERAPY _____ NONE _____

HAVE YOU EVER SMOKED? YES _____ NO _____

HOW LONG DID YOU SMOKE? _____

HOW MUCH DID YOU SMOKE _____ (PER DAY)

ARE YOU STILL SMOKING? YES _____ NO _____

WHEN DID YOU QUIT? _____

BLOOD SUGAR LEVEL _____ MG/DL

HT _____ WT _____

PRE INJ _____ POST INJ _____ ACTUAL DOSAGE GIVEN _____

INJECTION SITE _____

INJ TIME _____ SCAN TIME _____

TECHNOLOGIST _____

_____ DUAL TIME ACQUISITION PERFORMED