ULTRASOUND QUESTIONNAIRE

NAME: _____ DOB: _____ DATE: _____

Problems/complaints for today's visit?_____ Duration of symptoms? _____

Any prior imaging studies related to today's exam? YES NO **US MRI CT XRAY PET OTHER**
Date/Location: _____

Is your exam today related to an accident/injury? YES NO
Type of accident/injury _____ Date of accident/injury _____

Any prior surgeries in area being imaged today? YES NO
Type of surgery _____ Date of surgery _____

Any diagnosis of cancer or disease for **YOURSELF**? YES NO
Type_____ Date of Diagnosis? _____ Currently being treated? YES NO

Recent blood work performed (within last 6 months)? YES NO Results? Normal Abnormal _____

CIRCLE HISTORY/SYMPTOMS IN THE BOX BELOW FOR YOUR SPECIFIC EXAM TODAY

ABDOMEN/AORTA

NO SYMPTOMS SCREENING PAIN NAUSEA VOMITING DIARRHEA CONSTIPATION BLOATING

LUMP/MASS DIABETES SMOKER (current/former) ELEVATED CHOLESTEROL/MEDS BLOOD PRESSURE MEDS

RENAL/BLADDER

NO SYMPTOMS PAIN BLOOD IN URINE FREQUENT URINATION INCONTINENCE URGENCY DIABETES UTI's

KIDNEY STONES PROTEIN IN URINE DECREASE KIDNEY FUNCTION BLOOD PRESSURE MEDS

PELVIC/OBSTETRICS

LAST NORMAL PERIOD _____ # OF PREGNANCIES _____ # OF LIVE BIRTHS _____

BIRTH CONTROL ESSURE IUD TYPE? _____ HORMONE REPLACEMENT THERAPY _____

NO SYMPTOMS PAIN BLOATING CRAMPING HEAVY PERIODS SPOTTING DISCHARGE IRREGULAR BLEEDING

THYROID/SOFT TISSUE NECK

NO SYMPTOMS PAIN SWELLING DIFFICULTY SWALLOWING ENLARGED GLAND LUMP/MASS HOARSENESS

THYROID MEDICATION HYPERTHYROIDISM HYPOTHYROIDISM GRAVE'S DISEASE HX RADIOACTIVE IODINE BIOPSY

TESTES/SCROTAL

NO SYMPTOMS PAIN SWELLING PALPABLE LUMP ANTIBIOTICS VASECTOMY HX HERNIA

EXTREMITIES Right Leg Left Leg Right Arm Left Arm

NO SYMPTOMS LUMP/MASS PAIN SWELLING REDNESS NUMBNESS/TINGLING WEAKNESS ELEVATED CHOLESTEROL/MEDS

DIABETES BLOOD PRESSURE MEDS HEART DISEASE SMOKER SHORT OF BREATH HX OF BLOOD CLOT BLOOD THINNING MEDS

CAROTID

NO SYMPTOMS SCREENING BLOOD PRESSURE MEDS DIABETES HEADACHES NUMBNESS/TINGLING MEMORY LOSS STROKE

SPEECH/VISION PROBLEMS DIZZINESS/FAINTING HEART DISEASE SMOKER (current/former) ELEVATED CHOLESTEROL/MEDS

I attest that the above information is correct to the best of my knowledge.

Signature: _____

Staff only: *Additional information:* _____

_____ *Reviewed by:* _____