ULTRASOUND QUESTIONNAIRE

Name: _____DOB _____ Age _____ Date _____

Symptoms/complaints for today's visit: _____Duration_____

Prior Exams:

1. Have you had ANY previous radiology studies related to the area being scanned today? YES NO

   ULTRASOUND CT MRI NUCLEAR MEDICINE XRAY OTHER

   Date/Location: _____

Accident or Injury Related:

1. Are your symptoms related to an accident or injury? YES NO

   Date/Type: _____

Surgery and/or Biopsy

1. Any surgeries and/or biopsies in the area being examined today? YES NO

   Date/Type: _____

Other Conditions:

1. Do you have a personal history of cancer? YES NO

   Date of Diagnosis: _____ Type: _____

   Are you currently being treated for this type of cancer? YES NO

Any other known medical conditions: _____

PERSONAL HISTORY OF:	**YES**	**NO**	**CURRENT MEDICATION:**	**YES**	**NO**
Tobacco Use: Current Former			Antibiotics		
High Blood Pressure			Blood Pressure Meds		
High Cholesterol			Cholesterol Meds		
Blood Clots / Embolism			Blood Thinners		
Thyroid Disease			Thyroid Meds		
Liver Disease			**Females Only:**		
Kidney Disease/Failure			Hormone Replacement Therapy		
Heart Disease Heart attack Stroke			Birth Control: Pill Essure IUD Injection		
Diabetes: Type I or Type 2			Fertility Treatment / Medication		
SYMPTOMS RELATED TO TODAY'S EXAM:	**YES**	**NO**	**SYMPTOMS CONTINUED:**	**YES**	**NO**
Pain			Dizziness Fainting Lightheadedness		
Swelling			Headaches		
Nausea Vomiting			Slurred Speech		
Bloating Diarrhea Constipation			Blurred or Double Vision		
Blood in Urine			**Females Only:**		
Urinary Tract Infection			Irregular Periods / Abnormal Bleeding		
Shortness of Breath			# Pregnancies # Births		
Lump / Mass / Nodule			Date of Last Menstrual Cycle		

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

Signature: _____