Ultrasound Questionnaire PENRAD Imaging

NAME: _____ DOB _____ AGE _____ DATE _____

PRIOR EXAMS:

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

ULTRASOUND CT MRI NUCLEAR MEDICINE XRAY OTHER

Date/Location: _____

Are your symptoms related to an accident or injury? YES NO Date of injury: _____

SURGERY AND/OR BIOPSY:

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

Date/Type of surgery: _____

OTHER CONDITIONS:

Do **YOU** have a personal history of cancer? YES NO

Date of Diagnosis and Type of cancer: _____

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

Do **YOU** have Hypertension? YES NO

Do **YOU** have Diabetes? YES NO If yes, Type 1 or Type 2

FEMALES ONLY:

Birth control: YES NO If yes, please circle: PILL ESSURE IUD INJECTION OTHER

Hormone Replacement Therapy: YES NO Fertility Treatment/Medication: YES NO

First day of last menstrual cycle: _____

Number of Pregnancies_____ Number of Births_____

BRIEFLY DESCRIBE WHY YOUR DOCTOR SENT YOU HERE FOR AN ULTRASOUND TODAY:

SYMPTOMS: *(example: "I am having right sided abdomen pain with nausea and vomiting after eating".)*

_____

_____

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DURATION OF SYMPTOMS: *(example: "I have been having the above symptoms for 2 weeks".)*

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