1960 Digital Imaging

ULTRASOUND PROCEDURE QUESTIONNAIRE

PATIENT NAME_____ DATE: _____

EXAM ORDERED_____ REFERRING PHYSICIAN_____

SYMPTOMS_____ DOB: _____ AGE: _____

_____

_____ SEX M F

ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?

Y	N	ABDOMINAL PAIN	Y	N	LACK OF COORDINATION
Y	N	PELVIC PAIN	Y	N	CHEST PAIN
Y	N	PAIN IN LIMB(S)	Y	N	IRREGULAR HEARTBEAT/PALPITATIONS
		ARM OR LEG	Y	N	SYNCOPE/FAINTING
Y	N	SWELLING IN LIMB(S)	Y	N	SHORTNESS OF BREATH
		ARM OR LEG			

PLEASE LIST ALL ALLERGIES BELOW

1._____ 3._____

2._____ 4._____

PLEASE LIST ALL MEDICATIONS

1._____ 3._____

2._____ 4._____

PLEASE LIST ALL SURGERIES

1._____ 3._____

2._____ 4._____

HAVE YOU HAD PREVIOUS CT, XRAYS, OR MRI RELATED TO THIS PROBLEM?

IF YES, WHEN & WHERE: CT_____

XRAYS_____MRI_____

PATIENT'S INITIALS_____ LAST MENSTRUAL PERIOD_____