

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) ARM OR LEG	Y N IRREGULAR HEARTBEAT/PALPITATIONS
Y N SWELLING IN LIMB(S) ARM OR LEG	Y N SYNCOPE/FAINTING
	Y N SHORTNESS OF BREATH

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, XRAY, OR MRI RELATED TO THIS PROBLEM?			
IF YES, WHEN & WHERE: CT _____			
XRAY _____		MRI _____	
PATIENT'S INITIALS _____		LAST MENSTRUAL PERIOD _____	