

ULTRASOUND HISTORY AND SCREENING:

Today's Date ___/___/___ Patient's Name: _____

Last 4 Digits of SSN _____ Height _____ Weight: _____

Date of Birth: ___/___/___ Age: _____ Are you fasting? YES NO

Primary Care Provider _____ Referring Physician _____

Have you had a previous Ultrasound? YES NO

PLEASE ANSWER AS MANY QUESTIONS AS POSSIBLE. YOUR ANSWER MAY BE HELPFUL TO OUR STAFF IN INTERPRETING YOUR STUDY.

1. What type of Ultrasound are you having today?

2. Reasons for today's Ultrasound / Symptoms?

3. Are you currently taking any blood thinners? YES NO

4. Have you had any of the following removed? (yes or no in the blank)

____ Gallbladder ____ Ovaries ____ Uterus ____ Appendix ____ Other _____

Will a specialist need a copy of the study you are having today? If yes, please fill in:

Name of specialist: _____

Specialist Address: _____

Specialist phone number: _____

I have answered the above questions to the best of my knowledge and understand the information presented to me regarding ultrasound. I consent to the ultrasound examination.

Patient's/ Guardian's Signature and Printed Name: _____

Technologist Initials _____