ULTRASOUND QUESTIONNAIRE

LAKESIDE MRI & DIAGNOSTIC HEALTH

NAME: _____, _____
(first) (last)

HEIGHT: _____ WEIGHT: _____lbs

MEDICAL HISTORY

WHY HAS YOUR PHYSICIAN SENT YOU FOR AN ULTRASOUND? _____

ARE YOU EXPERIENCING PAIN OR OTHER SYMPTOMS? ☐YES ☐NO If yes, please list:

_____

ARE YOU BEING TREATED FOR ANY OTHER MEDICAL PROBLEM? ☐YES ☐NO If yes, please list:

_____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? ☐YES ☐NO If yes, please describe:

_____

HAVE YOU HAD ANY SURGERY? ☐YES ☐NO If yes, please list:

_____ DATE: _____

_____ DATE: _____

_____ DATE: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ☐YES ☐NO If yes, please list:

_____

HAVE YOU EXPERIENCED TRAUMA OR INJURY RECENTLY? ☐YES ☐NO If yes, please describe:

_____

HAVE YOU HAD ANY OTHER DIAGNOSTIC TESTS FOR THIS CONDITION? ☐YES ☐NO

WHERE?_____WHEN?_____WHAT KIND?_____

FEMALE PATIENTS ONLY

DATE OF LAST MENSTRUAL PERIOD: _____/_____/_____ *Post Menopausal?* ☐YES ☐NO

ARE YOU PREGNANT OR EXPERIENCING A LATE MENSTRUAL PERIOD? ☐YES ☐NO

ARE YOU TAKING ORAL CONTRACEPTIVES OR RECEIVING HORMONAL TREATMENT? ☐YES ☐NO

ARE YOU CURRENTLY BREASTFEEDING? ☐YES ☐NO

HOW MANY PREGNANCIES HAVE YOU HAD? _____

HOW MANY LIVE BIRTHS? _____

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding this information.

_____ _____
Signature Date

TECH INITIALS: _____