ULTRASOUND IMAGING HEALTH QUESTIONAIRE

Patient Name: _____ **Pt #:SP**_____

Age: _____ Sex: _____ DOB: ___/___/___ Ht. _____Wt. _____
Describe your **symptoms**: _____
_____
How long have you had this problem? _____
If you are having pain, where is the pain **predominant**? _____
Were you injured? Yes ___ No ___ If **yes**, how? _____
Have you had surgery on the body part being examined? Yes ___ No ___
If **yes**, what type of surgery: _____ Date: _____
List other surgeries (include dates): _____
_____

Have you had the following diagnostic tests? (Problem area only)

CAT Scan Yes ___ No ___	X-rays Yes ___ No ___
MRI Yes ___ No ___	Cardiac Catherization Yes___ No___
Nuclear tests Yes ___ No ___	Coronary Angiography Yes___ No___
Ultrasound Yes ___ No ___	Stress Tests Yes ___ No___
If Yes, please provide Location and Date of Service:	

Have you ever had?

	YES	NO		YES	NO
Diabetes			Asthma/ Respiratory Problems		
Hypertension/Cardiac Problems			Emphysema		
Elevated Cholesterol			Seizures		
Liver Disease			Cancer		
Urinary/Kidney Problems			Family History of any listed?		

Date of surgical sterilization: _____
Are you a smoker? Yes ___ No ___ If **yes**, how many years? _____
Do you currently or have you ever had any type of cancer? Yes ___ No ___
List the type of cancer and treatment type if applicable: _____
_____

Women only: Are you pregnant? Yes ___ No ___
Have you had prior Ultrasound during this pregnancy? Yes ___ No ___
* If yes, it was performed at: _____
My Last Menstrual Period began on: _____(Month, Day, Year)
Are you breast-feeding? Yes ___ No ___

I attest that, to the best of my knowledge, the above information is correct. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and the procedure I am about to undergo. If I have answered YES to any of the above questions, I will discuss any concerns and issues with the technologist BEFORE entering the study room.

Patient Signature _____ Date_____