ULTRASOUND HISTORY FORM

Patient Name: ________________________________ MR#: ____________________ Date: ____________

DOB: __________ Age: __________ Healthcare Provider: ______________________________________

ALL FEMALE PATIENTS: Date of last menstrual period: _______________ Number of pregnancies: ___________

Are you or could you be pregnant? ☐ **YES** ☐ **NO** Are you breast feeding? ☐ YES ☐ NO

Are you postmenopausal? ☐ YES ☐ NO Are you currently on hormones? ☐ YES ☐ NO

What kind: ____

Any history of fibroids? ☐ YES ☐ NO Any history of cysts: ☐ YES ☐ NO

Why did your healthcare provider order this test? ____

____

____

How long have you had these symptoms? ____

Specify location of symptoms: Area: __________________________________ LEFT RIGHT OTHER

Have you ever been diagnosed with cancer? ☐ YES ☐ NO

If Yes:

If yes, what kind? ____

Were you treated with chemotherapy? ☐ YES ☐ NO Radiation Therapy? ☐ YES ☐ NO

If you are here for a vascular ultrasound please answer the questions below?

Do you have pain in your leg or calf? ☐ YES ☐ NO

Do you have pain when walking? ☐ YES ☐ NO

Any swelling in your legs? ☐ YES ☐ NO

Tech Notes: ____

____

____

I attest the above information is correct to the best of my knowledge. I have read and understand the content of this form. I have had the opportunity to ask questions regarding the scan I am about to undergo.

____ ______________________________

Signature of Patient/Parent/Guardian **Date**

3405 College Street, Beaumont, Texas 77701 (409) 832-2211 Fax: (409) 434-4277