

BAY COLONY

Date of Birth: _____

Referring Physician: _____

ULTRASOUND QUESTIONNAIRE

WHY has your physician sent you for an Ultrasound? _____

Are you experiencing any of the following? (Please Check)

____ Pain ____ Fever ____ Nausea ____ Vomiting ____ Constipation ____ Diarrhea

If you have ever been diagnosed with the following? (Please Check)

____ Diabetes ____ High Blood Pressure ____ High Cholesterol ____ HIV ____ Kidney Stones

____ Hepatitis ____ Cirrhosis of the Liver

Have you ever been diagnosed with Cancer? _____ (If yes, What kind of Cancer and/or of what part of the body) _____

Do you have any significant health problems other than the ones we questioned you about?

If so, please list: _____

Have you had any of the following Surgeries? (Please Check)

____ Gallbladder ____ Appendix ____ Tubal Ligation ____ Hysterectomy

Please list any other surgeries: _____

Have you ever been a smoker? _____

How often do you drink alcohol? _____ times per week / month.

What is your approximate Height _____, and approximate Weight _____ lbs.

Have you had any of the following diagnostic studies?

Ultrasound: yes no What part of Body? _____

Cat Scan: yes no What part of Body? _____

MRI: yes no What part of Body? _____

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

Patient Signature _____

Date _____

Witness _____

Date _____

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ULTRASOUND QUESTIONNAIRE

FEMALES:

When was the first day of your last menstrual period? _____ Was it a normal Period? yes no

Is there any chance you could be pregnant? yes no

Are you currently on Birth Control or Hormone Replacement Therapy? yes no

How many times have you been pregnant _____ and How many live Births? _____

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

Patient Signature _____

Date _____

Witness _____

Date _____
