



ULTRASOUND PROCEDURE SCREENING FORM FOR PATIENTS

Date: ___/___/___ Patient Number: _____

Name: _____ Age: _____ Height: _____ Weight: _____

Date of Birth ___/___/___ Gender: M F Referring Physician: _____

Type of study to be performed: _____ Primary Care Phys: _____

Symptoms: _____

1. Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc.) of any kind? Yes No

If yes, please indicate the date and type of surgery:

Date ___/___/___ Type of Surgery _____

Date ___/___/___ Type of Surgery _____

2. Have you had a prior diagnostic imaging study or examination relevant to the study you are having today? Yes No

Table with 4 columns: Test, Date, Facility. Includes two rows of blank lines for data entry.

3. Do you have a personal history of cancer? Yes No

If yes, what type? _____

4. Are you currently taking any medication? Yes No

If yes, please list: _____

5. Are you allergic to any medication? Yes No

If yes, please list: _____

6. Are you pregnant, breastfeeding or suspect that you are pregnant? Yes No

LMP _____

I attest the above information is correct to the best of my knowledge.

Signature of person completing form: _____ Date _____

Form information reviewed by: _____ Technologist Physician