MR #: _______________

ULTRASOUND HISTORY AND SCREENING FORM

Patient Name: ____ Date: ________________________________

Sex: **M** **F** Height: _______________ Weight: _______________ DOB: _______________________ Age: _________________

Referring Physician: _________________________________ Procedure: ____

Are you pregnant? **YES** **NO** **N/A** Last Menstrual Period: __________________ Number of Pregnancies: ___________________

Reason you are here today for an exam:

Explain your medical problem in detail. *(What happened? Where did it happen? How long have you had this problem?)*

____

____

____

Do you have pain? **YES** **NO** Where? ____

Have you had any surgeries in the area(s) that are being imaged today? **YES** **NO** Where: _______________________________

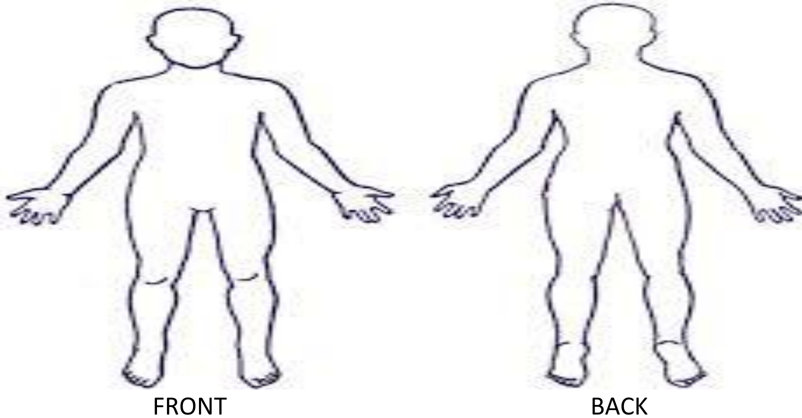
Have you taken any medication/sedation/alcohol today to help you relax for this procedure? **YES** **NO**

If yes, please list: ____time taken: __________________

Have you had a previous exam related to this problem? **YES** **NO** If yes, explain: ____

____

Draw on the figure below where your pain or symptoms are located:



Acknowledgement: I have answered these questions to the best of my knowledge and understand the information presented to me. I also give consent to One Step Diagnostic to perform an ultrasound as ordered by my physician. If my physician has ordered a pelvic ultrasound, I understand that this may include a transvaginal ultrasound.

Patient Name: ____

Patient Signature: ____

Date: ____

Technologist Name: ____

Technologist Signature: ____

Date: ____