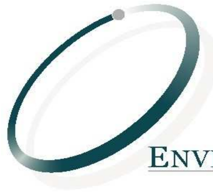

Ultrasound History & Screening Form

DATE: ____________________________

PATIENT: ____ **SEX**: M F

WEIGHT: _________ **HEIGHT:** __________ **DOB:** _____/____/______ **AGE:** __________

FEMALE PATIENTS/Date of Last Menstrual cycle: ________________

Explain in detail your medical problem that is the reason for your sonogram today. (Where is the problem? How long have you had this problem?)

____

____

Have you had a previous exam related to this problem? YES NO

If Yes, where was the exam performed? ____

List any other medical problems:

____

List all previous surgeries:

____

List all allergies:

____

Tech Notes:

____

____

I have answered these questions to the best of my knowledge and understand the information presented to me.

____ __________________

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE DATE

____ __________________

TECHNOLOGIST/WITNESS SIGNATURE DATE