

EASTSIDE DIAGNOSTIC IMAGING, PLLC**ULTRASOUND QUESTIONNAIRE**

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

PATIENT NAME:

DOB:

AGE:

Account Number:

SOCIAL SECURITY #:

FEMALE / MALE (PLEASE CIRCLE)

REFERRING PHYSICIAN/PHONE NUMBER:

IF YOU ARE PREGNANT PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY

ARE YOU OR COULD YOU BE PREGNANT? YES NO (INITIAL) _____

ARE YOU CURRENTLY BREAST FEEDING? YES NO (INITIAL) _____

WHAT SYMPTOMS OR COMPLAINTS BROUGHT YOU HERE? _____

PLEASE SPECIFY THE LOCATION AND DURATION OF SYMPTOMS: _____

WHICH SIDE? RIGHT LEFT OTHER _____

PLEASE LIST ALL PRIOR

[] NONE

DATE

SURGERIES:

[] _____ / /

[] _____ / /

[] _____ / /

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER OR SERIOUS ILLNESS? YES NO

IF YES, WHAT KIND? _____

IF YES, HAVE YOU HAD CHEMOTHERAPY? YES NO DATES: ____/____/____

IF YES, HAVE YOU HAD RADIATION THERAPY? YES NO DATES: ____/____/____

DO YOU HAVE ASTHMA?

YES NO

IF YES CURRENTLY SYMPTOMATIC? YES NO

HIGH BLOOD PRESSURE? YES NO

LUNG DISEASE YES NO

SHORTNESS OF BREATH? YES NO

HEART DISEASE YES NO

KIDNEY DYSFUNCTION? YES NO

IF YES DATE OF NEXT SESSION ____/____/____

ARE YOU CURRENTLY ON DIALYSIS? YES NO

ARE YOU OR HAVE YOU EVER BEEN A SMOKER? FOR HOW MANY YEARS? ____ PACKS PER DAY? ____

FOR PELVIC, TRANSVAGINAL AND/OR HYSTEROSONOGRAMS: (SEE SEPARATE CONSENT)**PLEASE MAKE SURE YOU DRINK 5 CUPS OF WATER PRIOR TO THE PELVIC EXAM****DO NOT EMPTY YOUR BLADDER**

DATE OF LAST MENSTRUAL CYCLE: ____/____/____

AGE OF MENOPAUSE

ARE YOUR PERIODS NORMAL HEAVY REGULAR

NUMBER OF MISCARRIAGES/ABORTIONS: _____

NUMBER OF PREGNANCIES _____

NUMBER OF CHILDREN _____

ARE YOU CURRENTLY TAKING HORMONE REPLACEMENT THERAPY YES NO IF YES, PLEASE SPECIFY TYPE _____

DO YOU HAVE A HISTORY OF FIBROIDS YES NO

DO YOU HAVE A HISTORY OF YES NO

DO YOU HAVE A HISTORY OF CYSTS YES NO

FOR VASCULAR ULTRASOUND

DO YOU HAVE ANY PAIN WHEN WALKING YES NO

DO YOU HAVE ANY SWELLING IN YOUR LEGS YES NO

DO YOU HAVE ANY CHRONIC DISEASES YES NO

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT _____

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TECHNOLOGIST NOTES:

TECH SIGNATURE