

Ultrasound History & Screening Form

Date: ____/____/____ Patient: _____ Sex: M F

Age: _____ DOB ____/____/____ Weight: _____ Height: _____

*****Female Patients Only*****

First day of Last Menstrual Cycle: _____

How many times have you been pregnant? _____

How many children have you delivered? _____

Why are you having this test today?

Have you had previous imaging 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: _____

Technologist 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 Signature Date: _____