



Ultrasound History & Screening Form

**DATE:** \_\_\_\_\_

**PATIENT:** \_\_\_\_\_

**SEX:** M F

**WEIGHT:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **AGE:** \_\_\_\_\_

**FEMALE PATIENTS/First day 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?)

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

If Yes, where was the exam performed? \_\_\_\_\_

List any other medical problems:

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List all previous surgeries:

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List all allergies:

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Tech Notes:

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

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PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE

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DATE

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TECHNOLOGIST/WITNESS SIGNATURE

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DATE