

ZWANGER-PESIRI RADIOLOGY, LLP

Ultrasound Questionnaire

Name of Patient: _____ Date: _____

All Ultrasound Patients

Reason for this ultrasound exam: _____

Yes/No Do you have any pain? Where? _____

Yes/No Do you have any tenderness to touch? Where? _____

Yes/No Do you have any abnormal lumps or masses? Where? _____

Yes/No Have you had any surgery? If yes, list type and date: _____

Yes/No Have you had any organs removed? If yes, which? _____

Yes/No Do you have any medical conditions? If yes, list and describe treatment : _____

Yes/No Do you currently have cancer? If yes, what type and treatment? _____

Yes/No Did you previously have cancer? If yes, what type and treatment? _____

Yes/No Recent abnormal blood tests? List type and results: _____

Yes/No Have you had any recent injury? When and what type? _____

Obstetrical Ultrasound Patients Only

Date of Last Menstrual Period (LMP) ? _____

Yes/No Do you have spotting or bleeding (female pelvic patients)?