concord imaging

Ultrasound Questionnaire

Please answer all questions

Patient Name: _____

Date: ___/___/___ Referring Doctor: _____

Follow Up Appointment Date: _____

Female Patients

Are you Pregnant? ____**Yes** **No**_____

Date of Last Menstrual Period: _____

All Patients

List any surgeries: _____

_____

_____

What symptoms are you having for this exam(s): Please explain

_____

_____

_____

Any previous films related to today's exam(s) (**CT scans/MRI/Ultrasound**) **If yes**, name of facility and date of exam(s): **Need for comparison**

Signature _____