THE IMAGECARE CENTERS

ULTRASOUND/X-RAY QUESTIONNAIRE

Please answer the following questions to the best of your ability. If you are unsure about any questions, please discuss them with your technologist. If you are here because you are or may be *pregnant*, please fill in the first line, and then skip to question #4. Thank you.

Name: _____ Date of Birth: _____

1. Please indicate the symptoms you currently have that are specific to your exam today: (***circle all that apply)***

Headache/Ringing in Ears	Upper Back	Hand (right/left)
Vision Loss/Changes	Lower Back	Leg (right/left)
Dizziness	Neck	Knee (right/left)
Numbness in arms/legs	Shoulder (right/left)	Foot (right/left)
Chest	Arm (right/left)	Abdomen/Pelvis

Pain, lump or mass (location):_____ Other:_____

2. How long have you had these symptoms?_____

3. Is your condition the result of an injury? Yes No
   Please describe:_____

4. Have you had any previous testing on the area being examined today? Yes No
   Ultrasound (date): _____ X-Ray (date):_____ MRI (date):_____ CT (date):_____

5. Have you had surgery on the area being examined today? Yes No
   Please describe:_____

6. Have you ever been diagnosed with cancer or a serious medical condition? Yes No
   Condition and location in your body:_____
   Radiation or chemotherapy: Radiation Chemotherapy

7. Do you have any known allergies? Yes No_____

8. Are you presently taking medication on a daily basis? Yes No_____

9. For X-Ray patients, is there *any chance of pregnancy*? Yes No
   Last Menstrual Period:_____

Reason for today's exam:_____

Patient and/or Guardian Signature:_____

Date:_____