



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 | Vision Loss/Changes | Dizziness |
| Numbness in arms/legs | Chest | Upper Back |
| Lower Back | Neck | Shoulder (right/left) |
| Arm (right/left) | Hand (right/left) | Leg (right/left) |
| Knee (right/left) | Foot (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** LMP: _____

Reason for today's exam: _____

*****Is this related to a motor vehicle accident? YES NO**

*****Is this related to a worker's compensation claim? YES NO**

Patient and/or Guardian Signature: _____ Date: _____