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
Shoulder (right/left)	Leg (right/left)	Lower Back	Neck
Arm (right/left)	Hand (right/left)	Upper Back	Chest
Knee (right/left)	Foot (right/left)	Abdomen/Pelvis	

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

2. How long have you had these symptoms:_____

3. Have you received the COVID-19 vaccine? **Yes** **No**

   If yes: Date of first injection: _____ Arm (circle one): **Left** **Right**

   Date of second injection(if applicable):_____ Arm (circle one): **Left** **Right**

   Date of Booster (if applicable): _____ Arm (circle one): **Left** **Right**

4. Is your condition the result of an injury? **Yes** **No**

   Please describe:_____

5. Have you had any previous testing on the area being examined today? **Yes** **No**

   Ultrasound (*date*):_____ X-Ray (*date*):_____ MRI (*date*):_____ CT (*date*):_____

6. Have you had surgery on the area being examined today? **Yes** **No**

   Please describe:_____

7. 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*

8. Do you have any known allergies? **Yes** **No** _____

9. Are you presently taking medication on a daily basis? **Yes** **No** _____

10. For X-Ray patients, is there any chance of pregnancy? **Yes** **No** LMP:_____

Reason for today's exam: _____

Patient and/or Guardian Signature:_____ **Date:** _____

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