Ultrasound Questionnaire

Name:_____ D.O.B.___/___/____ Sex: M/F WT:_____lbs.

LMP: _____ HT: _____

Why are you having the exam? (Symptom):_____

What side, location, body part are involved? (Location):_____

How long have you had this problem? (Duration):_____

If due to injury, how did it occur? (Mechanism of Injury):_____

YES NO Any prior imaging of the area? Where/when? _____

YES NO Any prior surgery of the area? Type/dates?_____

YES NO Do you have a history of being diagnosed with cancer? Type?_____

YES NO Are you in a lung cancer screening program with yearly CTs of the chest?

YES NO Do you now or have you ever smoked?

If YES, how many years did you smoke? _____ years
How many packs per day did you smoke? _____packs per day
How long ago did you quit? If still smoking, mark as "0": _____ years ago

I attest that the above information is correct to the best of my knowledge.

Signature: _____ Date: _____

Technologist Notes:

_____

_____

years X packs per day = _____ pack years