



## US PATIENT QUESTIONNAIRE

The following questions are to assure your safety and make us aware of any condition that could interfere with your US study. Please answer all questions.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SMI ID # \_\_\_\_\_  
(FOR OFFICE USE)

**ATTENTION:** Please answer the following questions completely. If you have any questions regarding your US exam please notify the receptionist or technologist.

**PLEASE CIRCLE YES OR NO TO THE FOLLOWING ITEMS:**

1. Do you have diabetes? YES NO
2. Do you have thyroid problems? YES NO
3. Do you have kidney problems? YES NO
4. If you are female, is there any chance of pregnancy? YES NO  
Date you started your last menstrual cycle? \_\_\_\_\_  
Are you currently taking birth control or hormones? YES NO
5. Have you had a previous CT/MRI/US? YES NO if yes, when and where? \_\_\_\_\_  
\_\_\_\_\_
6. Previous surgeries? \_\_\_\_\_  
\_\_\_\_\_
7. Medical history (family and personal) pertaining to your exam: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Please provide a summary of symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I HAVE ANSWERED THE QUESTIONS IN THIS SECTION TO THE BEST OF MY KNOWLEDGE.**

**PLEASE INITIAL:** \_\_\_\_\_

(FOR OFFICE USE ONLY)

TECHNOLOGIST INITIALS \_\_\_\_\_