BERGEN
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ACCREDITED BY THE AMERICAN COLLEGE OF RADIOLOGY

Account # _____ Today's Date _____

Name: Last _____ First _____

Date of Birth _____ Age _____

Type of Ultrasound _____

Send report to the following Physician _____

_____

_____

Are you pregnant? _____

What is the reason for having this exam? _____

Previous Radiology Tests of area of concern? _____ Where? _____

Any history of Cancer? _____

Any family history of Cancer of concerned area? _____

Family History of AAA (pt having screening Ultrasound of AAA only) _____

List current medications _____

Do you or have you ever smoked tobacco? _____

I verify that the answers I have provided to the questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam

Patient's signature _____ Date: ____/____/

NOTE: If you have previous films or reports with you, please give them to the receptionist before your exam