GENERAL ULTRASOUND REGISTRATION FORM

TECHNICIAN INITIALS

□ JD □ DD □ RC

Account #: _______________ Today's Date: ________________

Name: Last ____________________________________ First: ______________________________________

Date of Birth: _________________________ Age: ___________________

Type of Ultrasound: ____

Send report to the following Physician:

____

____

Are you pregnant? □ Yes □ No

What is the reason for this exam? ____

Previous radiology studies of area of concern? _________________________ Where? __________________________

Any personal history of cancer? ____

Any family history of cancer? ____

Family history of AAA (patient having screening ultrasound of AAA ONLY) _____________________________________

List any medical conditions relating to testing site: ____

____

List any prior surgical procedures: ____

List current medications: ____

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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 discs and/or reports with you, please give them to the receptionist upon check-in.