



**GENERAL  
ULTRASOUND  
REGISTRATION  
FORM**

<p><u>TECHNICIAN INITIALS</u></p> <p>US: <input type="checkbox"/> JD <input type="checkbox"/> DH <input type="checkbox"/> DB</p>
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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: \_\_\_\_\_

\_\_\_\_\_

Are you allergic to **LATEX**?  Yes  No

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.