



**GENERAL
ULTRASOUND
REGISTRATION
FORM**

TECHNICIAN INITIALS
US: JD DH DCB DM

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.