Park Avenue Radiologists, P.C.

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

ULTRASOUND QUESTIONNAIRE

PATIENT NAME: DOB: AGE:

Account Number: **SOCIAL SECURITY #:** FEMALE / MALE (PLEASE CIRCLE)

REFERRING PHYSICIAN/PHONE NUMBER:

IF YOU ARE PREGNANT PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY

ARE YOU OR COULD YOU BE PREGNANT? YES NO (INITIAL) _____

ARE YOU CURRENTLY BREAST FEEDING? YES NO (INITIAL) _____

WHAT SYMPTOMS OR COMPLAINTS BROUGHT YOU HERE? _____

_____

PLEASE SPECIFY THE LOCATION AND DURATION OF SYMPTOMS: _____

_____

WHICH SIDE? RIGHT LEFT OTHER _____

PLEASE LIST ALL PRIOR SURGERIES:

[ ] NONE DATE

[ ] _____ ____/____/_____

[ ] _____ ____/____/_____

[ ] _____ ____/____/_____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER OR SERIOUS ILLNESS? YES NO

IF YES, WHAT KIND? _____

IF YES, HAVE YOU HAD CHEMOTHERAPY? YES NO DATES: ____/____/____

IF YES, HAVE YOU HAD RADIATION THERAPY? YES NO DATES: ____/____/____

DO YOU HAVE ASTHMA?	**YES**	**NO**	**IF YES CURRENTLY SYMPTOMATIC?**	**YES**	**NO**
HIGH BLOOD PRESSURE?	YES	NO	LUNG DISEASE	YES	NO
SHORTNESS OF BREATH ?	YES	NO	HEART DISEASE	YES	NO
KIDNEY DYSFUNCTION?				YES	NO
ARE YOU CURRENTLY ON DIALYSIS?	YES	NO			

IF YES DATE OF NEXT SESSION ____/____/____

ARE YOU OR HAVE YOU EVER BEEN A SMOKER? FOR HOW MANY YEARS? _____ PACKS PER DAY? _____

F0R PELVIC, TRANSVAGINAL AND/OR HYSTEROSONOGRAMS: (SEE SEPARATE CONSENT)
PLEASE MAKE SURE YOU DRINK 5 CUPS OF WATER PRIOR TO THE PELVIC EXAM
DO NOT EMPTY YOUR BLADDER

DATE OF LAST MENSTRUAL CYCLE: ____/____/____

ARE YOUR PERIODS NORMAL HEAVY REGULAR

AGE OF MENOPAUSE

NUMBER OF MISCARRIAGES/ABORTIONS: _____

NUMBER OF PREGNANCIES_____

NUMBER OF CHILDREN _____

ARE YOU CURRENTLY TAKING HORMONE REPLACEMENT THERAPY YES NO IF YES, PLEASE SPECIFY TYPE _____

DO YOU HAVE A HISTORY OF FIBROIDS YES NO

DO YOU HAVE A HISTORY OF YES NO

DO YOU HAVE A HISTORY OF CYSTS YES NO

FOR VASCULAR ULTRASOUND

DO YOU HAVE ANY PAIN WHEN WALKING YES NO

DO YOU HAVE ANY SWELLING IN YOUR LEGS YES NO

DO YOU HAVE ANY CHRONIC DISEASES YES NO

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT DATE

_____ _____

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TECHNOLOGIST NOTES:

TECH SIGNATURE