RADIA®

CAROTID ARTERY ULTRASOUND QUESTIONNAIRE

Please help us make an accurate diagnosis by answering the following questions:

Why did your doctor order this exam?_____

❑ Yes ❑ No Do you have any allergies? If yes, please explain: _____

❑ Yes ❑ No Do you have a follow up appointment for today's exam? If yes, when: _____

❑ Yes ❑ No Have you had past imaging studies of the area of your body we are scanning today?

Type of imaging study: _____ When: _____ Name of facility: _____

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❑ Yes ❑ No Have you had any surgery on the area of your body that we are scanning today?

If yes, describe surgery: _____When: _____

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❑ Yes ❑ No Do you smoke, or have a history of smoking? If yes, number of packs/day: _____

❑ Yes ❑ No Are you diabetic? If yes, do you take insulin? ❑ Yes ❑ No

Do you have a history of any of the following:

❑ Yes ❑ No High blood pressure

❑ Yes ❑ No Heart disease

❑ Yes ❑ No Recent vision problems

❑ Yes ❑ No Difficulty speaking

❑ Yes ❑ No Stroke

❑ Yes ❑ No Atherosclerosis

❑ Yes ❑ No High cholesterol

❑ Yes ❑ No TIA (transient ischemic attack)

❑ Yes ❑ No Do you have numbness or tingling on a particular area of your body? If yes, where: _____

Other medical history we should know about? _____

_____

Signature of patient: _____ Date: _____

Name of person filling out this form, if other than the patient (please print): _____

Relationship to patient (please print): _____

Technologist Initials: _____

Affix Pt Sticker Here

(rev 9/15)