RADIA®

DVT 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 have a history of DVT? If yes, describe:_____

❑ Yes ❑ No Do you currently have a DVT? If yes, describe: _____

❑ Yes ❑ No Do you have a history of high blood pressure?

❑ Yes ❑ No Are you currently taking anticoagulants? If yes, how long? _____

❑ Yes ❑ No Are you taking birth control pills?

❑ Yes ❑ No Are you taking Hormone replacement therapy?

Do you have any of the following risk factors:

❑ Yes ❑ No Recent period of immobility

❑ Yes ❑ No Pregnancy

❑ Yes ❑ No Trauma

❑ Yes ❑ No Cancer

❑ Yes ❑ No Factor 5 Leiden deficiency

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: _____

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