RENAL ARTERY ULTRASOUND QUESTIONNAIRE

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

Why did your doctor order this exam?____

❏ Yes ❏ No Have you had anything to eat or drink in the past 6 – 8 hours?

❏ 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 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 Kidney disease If yes, describe: ____

❏ Yes ❏ No High blood pressure

❏ Yes ❏ No Atherosclerosis

❏ Yes ❏ No Fibromuscular dysplasia

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)