PELVIC 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 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 we are scanning today?

If yes, describe surgery: ____________________When: __________

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❏ Yes ❏ No Have you ever had cancer? When: __________ Type: ______________

❏ Yes ❏ No Do you currently have pain? Where: ________________

❏ Yes ❏ No Are you post-menopausal? If yes, how long: __________

❏ Yes ❏ No Are you pregnant? Date of last menstrual period: ______________

❏ Yes ❏ No Have you been pregnant before? If yes, how many times: ______ How many deliveries: _____

❏ Yes ❏ No Do you have an IUD?

Are you taking any of the following:

❏ Yes ❏ No Birth control pills

❏ Yes ❏ No Depo-Provera

❏ Yes ❏ No Hormone replacement therapy

❏ Yes ❏ No Tamoxifen

Do you have a history of the following:

❏ Yes ❏ No Fibroids

❏ Yes ❏ No Endometriosis

❏ Yes ❏ No Ovarian cysts

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)