US Information Sheet

Patient Name:	Date of Birth:	Age:
Referring Physician:		
When is your next appointment with your physician?		

FEMALES ONLY		
Are you pregnant?	❑ Yes ❑ No	Last Menstrual Period:
Have you been pregnant before?	❑ Yes ❑ No	# of pregnancies _____ # of live births _____

REASON FOR EXAM		
❑ Check fetal size and dates	❑ Pain and/or swelling	❑ Other:
Describe:		

OTHER EXAMS FOR YOUR CURRENT PROBLEM OR CONDITION	
Type of Exam	**Facility or Hospital where exam was performed**
❑ None	
❑ X-Ray	
❑ CT	
❑ MRI	
❑ Ultrasound	

PREVIOUS SURGERIES ON AREA TO BE SCANNED			
❑ None	❑ Hysterectomy	❑ Gallbladder	❑ Other:

GENERAL QUESTIONS			
Are you allergic to latex?	❑ Yes ❑No	Are you diabetic?	❑ Yes ❑No
Do you have high blood pressure?	❑ Yes ❑No	Do you smoke?	❑ Yes ❑No
Current Medications:			
Allergies:			

ABDOMINAL AORTIC ANEURYSM SCREENING QUESTIONS ONLY	
Have you ever had a prior AAA screening?	❑ Yes ❑No
Risk Factors to be met:	
Do you have a family history of AAA	❑ Yes ❑No
Are you a male 65-75 yrs of age with a history of smoking 100 cigarettes	❑ Yes ❑No
List other risk factors not yet defined:	

Patient Signature: _____

Ultrasound Technologist Signature: _____