



ULTRASOUND CLINICAL QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Please describe what specific complaints/symptoms have been most bothersome to you?

\_\_\_\_\_  
\_\_\_\_\_

3. How long have you had these complaints/symptoms? \_\_\_\_\_

Did these complaints/symptoms come on suddenly or gradually? \_\_\_\_\_

4. Do you have a history of cancer? If so, what type? \_\_\_\_\_

5. Have you had any previous surgery?:

Date

Type

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Have you had any prior tests?

MRI	Date: _____	Place: _____
CT scan	Date: _____	Place: _____
Ultrasound	Date: _____	Place: _____
Nuclear Medicine	Date: _____	Place: _____
PET scan	Date: _____	Place: _____
Other _____		

