# Ultrasound History & Screening Form

**DATE:** ______________________________

**PATIENT:** ____________________________________________ **SEX**: ☐ M ☐ F

**WEIGHT:** _________ **HEIGHT:** __________ **DOB:** _____/____/______ **AGE:** __________

**FEMALE PATIENTS/Date of Last Menstrual cycle:** _________________

Explain in detail your medical problem that is the reason for your sonogram today. (Where is the problem? How long have you had this problem?)

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Have you had a previous exam related to this problem? ☐ YES ☐ NO

If Yes, where was the exam performed? ________________________________________________

List any other medical problems:

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List all previous surgeries:

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List all allergies:

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Tech Notes:

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I have answered these questions to the best of my knowledge and understand the information presented to me.

__________________________________________________ ____________________

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE DATE

__________________________________________________ ____________________

TECHNOLOGIST/WITNESS SIGNATURE DATE