Ultrasound Patient Questionnaire

Patient Name: _____

Date of Birth: _____

What kind of problems are you having? _____

_____

How long have you been having this problem? _____

Please list all surgeries and approximate dates: _____

_____

_____

What, if anything, have you had to eat today?_____

_____

When is your next scheduled appointment with your doctor? _____

Please list any health problems: _____

_____

FEMALE PATIENTS ONLY:

When was your last menstrual period? _____

Are you pregnant and if so how far along are you? _____

How many pregnancies have you had? _____