EVE'S BREAST CENTER
ULTRASOUND QUESTIONNAIRE

Patient Name**:** DOB**:**

Refer Physician: Physician #**:**

What type of ultrasound exam are you on scheduled for? Please mark all that ap ply:

☐ **Abdominal**	☐ **Breast**	☐ **Carotid**	☐ **Prostate**	☐ **Pelvis**	☐ **Thyroid**	☐ **Soft Tissue**	☐ **Venous**	
Other (Please List)								

Have you had any imaging exam performed for this condition before? ☐ **Yes** ☐ **No**

Please mark all that apply:

☐ **X-Ray**	☐ **CT Scan**	☐ **Ultrasound**	☐ **MRI**	☐ **Doppler**	☐ **Bone Scan**	☐ **Mammogram**

Did they show anything?	
Injury / Condition:	
Recent Surgeries:	
Reason for visits:	
Current Pain Description	

Area of pain ☐ **Left** ☐ **Right** ☐ **Both**

T**ype of Pain:** ☐ **None**	☐ **Sharp**	☐ **Burning**	☐ **Aching**	☐ **Tingling**	☐ **Numbness/ Other:**	

WOMEN ONLY: Pelvic Exam

Chance you are Pregnant?	☐ **Yes**	☐ **No**	**Date of last mentrual cycle:**

Patient Signature: ***Date***: