

Patient Information for Ultrasound Examination
Complete and Fax to (770) 980-8975

Patient Name _____ **Date** ___/___/___ **DOB** ___/___/___

What symptoms are you experiencing? _____

For how long? _____

Answer Yes or No to the following:

- | | |
|--------------------------------------|--|
| High Bloods Pressure: Yes ___ No ___ | Congestive Heart Failure: Yes ___ No ___ |
| Diabetes: Yes ___ No ___ | Thyroid (Hyper, Hypo): Yes ___ No ___ |
| Renal Disease: Yes ___ No ___ | Renal Stones: Yes ___ No ___ |
| UTI's: Yes ___ No ___ | Blurred Vision: Yes ___ No ___ |
| Headaches: Yes ___ No ___ | Dizziness: Yes ___ No ___ |
| Fainting: Yes ___ No ___ | Weakness in arms or legs: Yes ___ No ___ |
| Elevated Cholesterol: Yes ___ No ___ | |

Gynecologic History: (Women Only)

- When was your last menstrual period? _____
- Are (were) your periods regular between ages 18 and 40 years? _____
- Are you pregnant or do you think you may be pregnant? _____
- Did you have intervals with few or no bleeding cycles, except while pregnant? _____
Age _____ Length of time _____
- Have you had a hysterectomy? _____
- If yes, what year? _____ Were your ovaries removed? _____
- Have you entered menopause? _____ When? _____
- Are you taking Hormone Replacement Therapy? _____ How long? _____

Surgical/Medical History:

What medications do you take?

What medications are you allergic to?

