

ULTRASOUND
Valley Imaging Center

Please Print

Patient ID # _____

Exam _____

Date: _____

Ordering Physician: _____

Office #: _____

Patient Name: _____ Age: ____ Sex: Male Female

DOB: _____ Weight: _____ Height: _____

Home Phone #: _____

Please describe your symptoms and/or complaints: _____

Allergies? Yes No

If yes, what type _____

Do you have a history of a bleeding disorder? Yes No

Are you diabetic? Yes No

Do you smoke? Yes No

If yes, how long _____

Do you have asthma/COPD? Yes No

Do you have a history of TIA/Stroke? Yes No

Do you have stents? Yes No

Do you have a history of heart failure? Yes No

Do you have any renal problems? Yes No

Have you had any surgeries? Yes No

If yes, what type and when _____

Breast Ultrasound Patients Only

Are you currently taking hormones? Yes No

If yes, what kind and for how long? _____

Have you ever had a mammogram? Yes No

If yes, what facility and when? _____

Is there a family history of breast cancer? Yes No

If yes, what relation to you? _____

OB/Pelvic Patients Only

Total # of Pregnancies: _____ Deliveries: _____

Total Abortions/Miscarriages: _____ Last Menstrual Period (Date): _____

For Office Use Only

Ultrasound Impression: _____

Technologist: _____