RIVER OAKS
MRI & DIAGNOSTIC

# Ultrasound Patient History Form

Patient Name: ________________________________________DOB: _____________
Referring Physician:__________________________

**Please answer the following questions to the best of your knowledge.**

| Age | Weight |
|---|---|

What symptoms do you have relating to today's exam and when did they start?
_______________________________________________________________________
_______________________________________________________________________
_________
_______________________________________________________________________
_______________________________________________________________________
_______

List any surgeries you have had relating to today's exam (Date-type of surgery)
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________
_______________________________________________________________________
____

Is your problem related to an injury, trauma, or auto accident? ____Yes ______No
If yes, date of injury? _______________

Please describe how you were injured:
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
____________

| Yes | No | Question |
|---|---|---|
| Yes | No | Any previous imaging related to the reason for today's exam?<br>Type of exam______________________________________________________<br>When was it done?_________________________________________________<br>Where was it done?________________________________________________ |
| Yes | No | Are you pregnant? Date of last menstrual cycle:_________________________ |
| Yes | No | Have you had recent pregnancy test? When was it done? ______________________<br>If yes, was it by _______Blood _______Urine ________ |
| Yes<br>Yes | No<br>No | Have you had a Hysterectomy?<br>Were your ovaries removed? |
| Yes | No | Have you ever has an ectopic or tubal pregnancy? |

| Total Number of Pregnancies:__________ | Total Number of Miscarriages:______________________ |
|---|---|

Patient/Guardian signature_________________________________________Date:_____________

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