



**ULTRASOUND EXAM QUESTIONNAIRE**

Patient Name: \_\_\_\_\_

E-mail address \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Your exam, (images and report), will automatically be sent to your Oregon Clinic Doctor**

**Please provide the name of your current Primary Care Physician** \_\_\_\_\_

**Would like today's Exam Report sent to another doctor? YES NO**

**If yes, please provide the physicians name and address:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

Are you Diabetic? YES NO

Any personal history of cancer? YES NO

If yes, when were you diagnosed, where was it located, and what were the treatments?

DATE	LOCATION	TREATMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a prior testing on the area being scanned today? YES NO

DATE	WHERE WAS IT DONE	WHAT KIND (Ultrasound, CT,MR, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had any surgery, biopsy, or shunt in that same area? YES NO

DATE	SURGERY SITE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

**TO BE COMPLETED BY THE OREGON CLINIC STAFF**

Reason for scan? \_\_\_\_\_

Tech notes \_\_\_\_\_

Tech's initials \_\_\_\_\_

