SOUTHWEST DIAGNOSTIC CENTER

ULTRASOUND SCREENING

Date: _____

Patient Name: _____ DOB: _____

Sex: _____ Weight: _____

Injury Information: □ Work □ Automobile □ Fall □ Other Date of injury: _____

Describe your symptoms and or reason for your visit today:

_____

_____

_____

_____

Have you had a previous exam related to this problem? YES NO

If YES, where was it performed? _____

ALLERGIES: _____

PREVIOUS SURGERIES: _____

_____

FEMALE PATIENTS: DATE OF LAST MENTRUAL CYCLE: _____

_____
Signature

_____
Date