# ULTRASOUND QUESTIONNAIRE

**GENERAL INFORMATION** Date _____

| NAME | | | ☐ MALE ☐ FEMALE |
|---|---|---|---|
| WEIGHT | HEIGHT | AGE | BIRTHDATE |

Referring Physician: _____

Briefly describe the problem(s) you are experiencing that made you see your doctor: _____

_____

_____

_____

☐ No ☐ Yes Have you ever had any surgery in the area you are currently having problems?

Type of surgery _____

☐ No ☐ Yes Do you have a personal history of cancer in any part of your body?

What part of your body and when was this diagnosis made? _____

_____

**PLEASE INDICATE BELOW ANY RELATED STUDIES YOU HAVE HAD WITHIN THE LAST 3 YEARS, WHEN THEY WERE PERFORMED AND AT WHICH FACILITY:**

X-rays_____ MRI _____

Computed Tomography (CT) _____ Ultrasound _____

**TO OUR FEMALE PATIENTS**

Date of your last menstrual cycle _____

Do you take hormones? ____ yes ____ no

The standard of care for Pelvic Ultrasound includes a scan using a vaginal transducer. If you have never been sexually active, please inform your technologist.

I give my consent for the vaginal transducer to be used for my pelvic ultrasound.

**X** _____

*Signature*

I understand that I am requesting services from Bend Memorial Clinic, PC that may not be approved or covered by my insurance company. Authorization is not a guarantee of payment. Claims payment will be based on member eligibility, medical necessity benefits in effect at the time of service. I am agreeing to pay for these services personally if these services are not approved or covered.

**X** _____

Signature of Patient or Responsible Party Requesting Services