babyimage 3d/4d Ultrasound

Patient History

Name (Last, First):_____

Date of Birth:_____ Age:_____ Weight:_____

Social Security Number: _____

Phone # : Home _____ Work/Cell _____

Address: _____

What are the symptoms that brought you to our center? _____

_____

When did this first occur? _____

What is the doctor's name that referred you here? _____

Were you injured? YES / NO

If yes, specify when and how: _____

Diabetes	Yes / No	Glaucoma	Yes / No
Liver Disease	Yes / No	Sickle Cell	Yes / No
Hypertension	Yes / No	Kidney Disease	Yes / No
Hepatitis	Yes / No	HIV Positive	Yes / No
Heart Disease	Yes / No	Stroke	Yes / No

Seizures Yes / No

If yes, list type? _____

History of Cancer Yes / No

If yes, treatment type for cancer? _____

Are you taking any medications? Yes / No

If yes, list all medication you are on: _____

List any medications you have taken today: _____

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Pertaining to today's visit have you had any of the following exams?

Cat Scan	Yes / No	MRI	Yes / No
X-Ray	Yes / No	Ultrasound	Yes / No

If yes, when? _____

Where? _____

Results? _____

Have you ever had any surgeries? Yes / No (Circle One)

If yes, list and date all surgeries: _____

_____

_____

Female Patients

Is there any possibility you are pregnant? Yes / No

Date of last menstrual period: _____

Total pregnancies: _____

Miscarriage? Yes / No

If yes, how many? _____

Tubal Ligation? Yes / No

Have you had a hysterectomy? Yes / No

If yes, were your ovaries removed? Yes / No

If yes, which: _____

Do you have an IUD? Yes / No

Do you use birth control pills? Yes / No

I acknowledge that the above information is correct.

Patient signature: _____ Date: _____

Interpreter: _____ Date: _____

Emergency Contact Name: _____

Emergency contact phone: _____