ROSEVILLE
DIAGNOSTIC IMAGING

ULTRASOUND

Patient Name:_____Date of Birth: _____/_____/_____

Weight:_____Height:_____

YES	NO	
❑	❑	Have you had a Cough, Fever, or any Flu-like symptoms within the past 2 weeks?
❑	❑	Have you recently come into contact with anyone who was COVID positive?
❑	❑	Any recent travels outside of the USA?

Have you had an Ultrasound before? ❑YES ❑NO
If YES: When: _____ Where: _____ What type: _____

Why are you having this Ultrasound today? _____

_____

Any Pain? ❑YES ❑NO For how Long? _____

List Previous Surgeries: _____

Female Patients Only:

Are you pregnant? ❑YES ❑NO **First** day of last menstrual period: ____/____/_____

Number of Pregnancies: _____ Number of Abortions/Miscarriages: _____

Number of live births: _____ Number of Ectopic pregnancies: _____

Are you having Pelvic Pain? ❑YES ❑NO For how long? _____

Any abnormal bleeding? ❑YES ❑NO For how long? _____

Hysterectomy? ❑YES ❑NO Ovaries Removed? ❑YES ❑NO Right / Left

Are you on any hormone replacement? ❑YES ❑NO

Form of birth control currently using: _____

I attest that the above information provided by me is correct to the best of my knowledge. I have read and understood the entire content of this form and I have had the opportunity to ask any unclear issue in this regard.

►Signature: _____Date: _____/_____/_____

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