Reston Radiology Consultants

ULTRASOUND MEDICAL HISTORY

Name: _____ Date: _____

In case of emergency, notify: _____ Phone: _____

Do you have any allergies to latex? _____

Current Weight _____

Please circle if you have had any of the following:

Hepatitis/Jaundice	Heart disease	High blood pressure	Tuberculosis (TB)
High Cholesterol	Kidney/Bladder infections	Blood clots (DVT or PE)	
Cancer	Gallbladder Disease	Stomach/Bowel problems	

Other medical problems:_____

Other hereditary diseases: _____

Family history of cancer: _____

Surgical History: Please circle if you have had any of the following:

Appendectomy Cholecystectomy (gallbladder)
Other Operations:_____

Medications: Include vitamins, Hormones, Birth Control, Sleeping Pills, etc. _____

_____

_____

FEMALES ONLY:

When was the first day of your last menstrual period?_____
Are you currently bleeding? _____
Are you post menopausal? _____If yes at what age did your periods stop?_____
STDs _____

Number of times you have been pregnant?_____
Number of births?_____
Do you have any history of ectopic pregnancies?_____
Have you ever had any cesarean sections?_____

Obstetric History:
Are you experiencing any bleeding or cramping with this pregnancy how long have you had these symptoms?

_____

Is this the first ultrasound for this pregnancy?_____

If you have had ultrasounds at another facility which facility were they done? _____

_____

When is your due date? _____

Describe any birth defects? _____

Please circle if you ever had:

Endometriosis	Hysterectomy/Myomectomy	Uterine Fibroids	Tomoxifen use
Ovaries removed	Ectopic pregnancy	Treatment of cervix (Laser, LEEP, cryo, cone biopsy)	Laparoscopy
Infertility	D&C		