CT OR Ultrasound EVALUATION FORM

Please help us evaluate your problem by completing this form

NAME:______________________________________**Age:**___________**Date:**___________

1. What was your chief complaint when you visited your doctor? ________________________

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2. If with pain; please indicate **where**: ____

   How long has it been hurting? ___________________

3. Any weight loss, fever, or other associated symptoms? _____________________________
4. Any surgeries in the general area? ____
5. Any serious medical diseases; especially cancer? __________________________________

6. Have you had any other imaging tests done on the body part we are imaging today? **YES / NO**
   X-Rays? ____
   CT Scan? ____
   MRI Scan? ____
   Bone Scan? ____
   Ultrasound?____

If **yes** to any of the above, **please list when** and **where** that **imaging was performed?**

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CT Patients Only: Have you had recent bloodwork drawn? _______________________________

If yes, when & where was that done? ____

Female Patients Only:

Are you pregnant? ________ If no, please give the date of your LMP:_________________________