RADIA®

# OB ULTRASOUND QUESTIONNAIRE

**Please help us make an accurate diagnosis by answering the following questions:**

What is the first day of your last menstrual period? _____

❑ Yes ❑ No Have you been pregnant before? If yes, how many times? _____ Number of deliveries? _____

❑ Yes ❑ No Is your bladder full?

❑ Yes ❑ No Do you have any allergies? If yes, please explain: _____

❑ Yes ❑ No Do you have a follow up appointment for today's exam? If yes, when: _____

**Do you have a history of any of the following:**

❑ Yes ❑ No High blood pressure

If yes, is your high blood pressure:

❑ Yes ❑ No Pre-existing

❑ Yes ❑ No Gestational

❑ Yes ❑ No Heart disease If yes, describe: _____

❑ Yes ❑ No Kidney disease If yes, describe: _____

❑ Yes ❑ No Edema If yes, describe: _____

❑ Yes ❑ No High protein in your urine

❑ Yes ❑ No Diabetes

If yes, is your Diabetes:

❑ Yes ❑ No Gestational

❑ Yes ❑ No Type 1

❑ Yes ❑ No Type 2

❑ Yes ❑ No Do you take insulin?

❑ Yes ❑ No If you do not take insulin, do you control your diabetes with diet?

❑ Yes ❑ No Do you smoke, or have a history of smoking? If yes, number of packs/day: _____

❑ Yes ❑ No Do you drink alcohol? If yes, how much and how often? _____

Other medical history we should know about? _____

_____

Signature of patient: _____ Date: _____

Name of person filling out this form, if other than the patient (please print): _____

Relationship to patient (please print): _____

Technologist Initials: _____

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