Nebraska Health Imaging

Ultrasound History Form

PATIENT INFORMATION **Fall Precaution** □ YES □ NO

Last Name	**First Name/Middle Initial**	**Gender**	**Race**
Date of Birth (MM/DD/YYYY) / /	**Age**	**Height**	**Weight**

PERSONAL HISTORY

Have you had a previous imaging study related to this problem? ☐ Yes ☐ No

If yes, What exam? ☐ CT ☐ MRI ☐ Ultrasound ☐ X-ray ☐ Other

What Facility? _____

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding □ YES □ NO Date of last period: _____

ACKNOWLEDGMENT

I have answered these questions to the best of my knowledge and understand the information presented to me.
If I am to have intravenous contrast with my procedure, I have been informed of the risks.

_____ _____

PARENT/ GAURADIAN SIGNATURE **DATE**

_____ _____

TECHNOLOGIST SIGNATURE **DATE**