Diagnostic Medical Imaging, LLC
2170 West 68th Street Suite 1-2
Hialeah, Florida 33016

Patient History for Ultrasound

Patient Name: _____ **Date** ___/___/____

Social Security Number: _____-_____-_____

Height _____ **Weight** _____ **Referring Doctor** _____

Test Ordered _____ **Why** _____

Are you Pregnant? ☐ **NO** ☐ **YES**

1. **Previous Nuclear Medicine Tests or Ultrasound Tests:**
   _____ **Date** ___/___/___ **Where** _____
   _____ **Date** ___/___/___ **Where** _____
   _____ **Date** ___/___/___ **Where** _____
2. **Previous X-Rays, CT, MRI, BKG, Other Tests:**
   _____ **Date** ___/___/___ **Where** _____
   _____ **Date** ___/___/___ **Where** _____
   _____ **Date** ___/___/___ **Where** _____
3. **Complaints (i.e. Bone pain)** _____
   _____
4. **Other Medical Problems and Treatments received (when):**
   _____
   _____
5. **Surgeries, Traumas, Fractures (when):**
   _____
   _____
6. **Please list any medications that you are currently taking:**

Medication	Dosage	Time/Frequency	Last Dose On

Revised 04/08