Diagnostic Medical Imaging, LLC
6517 Taft St. Suite 103
Hollywood, Florida 33024

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