Princeton Radiology
Excellence in Imaging

Ultrasound Questionnaire

Name:_____ D.O.B.___/___/___ Sex: M/F WT:_____lbs.

First day of your last/current period (female patients) : _____ HT: ____

☐ ***YES NO*** ☐ ***Have you received a COVID vaccine? If yes, please answer the following: Pfizer/Moderna/J&J***
1st dose date: _____ ***Arm: RIGHT / LEFT*** ***2nd dose date:*** _____ ***Arm: RIGHT / LEFT***

Why are you having the exam? (Symptom):_____

What side, location, body part are involved? (Location):_____

How long have you had this problem? (Duration):_____

If due to injury, how did it occur? (Mechanism of Injury):_____

☐ YES NO ☐ Any prior imaging of the area? Where/when? _____

☐ YES NO ☐ Any prior surgery of the area? Type/dates?_____

☐ YES NO ☐ Do you have a history of being diagnosed with cancer? Type?_____

☐ YES NO ☐ Are you in a lung cancer screening program with yearly CTs of the chest?
☐ YES NO ☐ Do you now or have you ever smoked?

If YES, how many years did you smoke? _____ years
How many packs per day did you smoke? _____packs per day
How long ago did you quit? If still smoking, mark as "0": _____ years ago

I attest that the above information is correct to the best of my knowledge.

Signature: _____ Date: _____

Technologist Notes:

_____

_____

years X packs per day = _____ pack years