DIAGNOSTIC RADIOLOGY CENTER OF THE TREASURE COAST, INC.

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ULTRASOUND SCREENING FORM FOR ABD/RENAL/RETRO

PLEASE PROVIDE THE FOLLOWING INFORMATION. (PRINT CLEARLY)

NAME_____ DATE_____

DOB_____ AGE _____

REFERRING PHYSICIAN_____

REASON FOR EXAM (SYMPTOMS) _____

_____

WHEN DID SYMPTOMS FIRST BEGIN?_____

SURGICAL HISTORY _____

_____

PREVIOUS RADIOLOGY/ULTRASOUND STUDIES
_____

ANY PERSONAL HISTORY OF THE FOLLOWING: PLEASE CIRCLE

KIDNEY- CYSTS STONES HYDRONEPHROSIS MASS

GALLBLADDER- STONES SLUDGE POLYPS

PANCREAS- PANCREATITIS CYST MASS

LIVER- MASS CYST CIRRHOSIS ELEVATED LIVER FUNCTION TEST

ASCITIES- YES NO

AORTIC ANEURYSM- YES NO
IF YES HOW LONG AGO?_____ SURGICALLY REPAIRED? YES NO