DIAGNOSTIC RADIOLOGY CENTER OF THE TREASURE COAST, INC.

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ULTRASOUND SCREENING FORM
CAROTID/VENOUS/ARTERIAL

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

CAROTID- BRUIT WEAKNESS STROKE SURGERY RT OR LT

VISUAL CHANGES HEADACHE DIZZINESS HIGH BLOOD PRESSURE

SMOKER MEMORY LOSS OTHER _____

LEGS- PAIN SWELLING DISCOLORATION (BLUE OR RED)

HOT EXTREMITY(S) COLD EXTREMITY(S) CELLULITIS

POOR CIRCULATION

IF YES TO ANY WHICH LEG OR ARM? RT LEG /LT LEG RT ARM/LT ARM
HOW LONG?_____