Account # ______________ Tech:____________ Date: ____________

Abdominal/Renal Imaging Worksheet (Female)

Name: ____________________________ Age:_______ Date of Birth:_________

Date of Last Menstrual Period:____________________

Are you Pregnant? (Please circle) No/Yes If Yes, how many weeks?____________

Reason for today's exam: (Routine/Follow-up/Medical problem or Complaint):

____

____

List previous surgeries: ____

____

____

List Current Medications (including hormones, birth control, etc):

____

____

Is there a family history of cancer? (Please circle) No/Yes If yes, please explain

____

____

IF YOU HAVE BROUGHT PREVIOUS FILMS OR REPORTS WITH YOU, PLEASE GIVE THEM TO THE RECEPTIONIST BEFORE YOUR EXAM.