DIAGNOSTIC RADIOLOGY CENTER OF THE TREASURE COAST, INC.

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# ULTRASOUND SCREENING FORM
# THYROID/BREAST/TESTICLE/BLADDER

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

THYROID- ABNORMAL BLOOD WORK CYST MASS GOITER

BLADDER- TROUBLE EMPTYING INCONTIENCE URGENCY PAIN
OTHER- PLEASE LIST _____

BREAST- PRIOR MAMMO- YES NO IF YES WHERE?_____ WHEN_____
PALPABLE LUMP YES NO WHERE?_____ HOW LONG?_____
HISTORY OF: CYST MASS NIPPLE DISCHARGE PAIN
IF YES TO ANY WHERE?_____
*NO ULTRASOUND WILL BE READ WITH OUT PRIOR MAMMO FILMS*

FOR MEN ONLY:
TESTICLE- CYST MASS ENLARGMENT OR SWELLING
PAIN IF YES RT OR LT HOW LONG?_____
ANY TRAUMA TO AREA? IF YES WHEN?_____