



# Houston MRI

Diagnostic Radiology of Houston

## ULTRASOUND HISTORY FORM

Phone: 713.425.8100 • Fax Orders: 713.425.8182

- 2600 N. Gessner, Ste. 150, Houston, TX 77080
- 5630 E. Sam Houston Pkwy N., Houston, TX 77015
- 1336 Pin Oak Road, Katy, TX 77494

Patient name: \_\_\_\_\_  
First Name MI Last Name

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ultrasound of: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

When is your next follow up appointment with your doctor? \_\_\_\_\_

Explain present condition: \_\_\_\_\_

Do you have or have you had any of the following:

- AIDS/HIV  Yes  No
- Hypertension  Yes  No
- Diabetes  Yes  No
- Hepatitis  Yes  No
- Smoker  Yes  No
- Renal Disease  Yes  No
- Liver Disease  Yes  No

- Lupus  Yes  No
- Stroke  Yes  No
- Ulcers  Yes  No
- High Cholesterol  Yes  No
- Cancer  Yes  No

If yes, what type? \_\_\_\_\_

Please list any other medical conditions not listed above:

Have you ever had surgery?  Yes  No

List any and all past surgeries and the year they were done:

Are you currently taking or have you recently taken any medications?  Yes  No

If yes, please list:

Are you allergic to any medications?  Yes  No

If yes, please list:

### FEMALE PATIENTS ONLY

Onset of last menstrual period. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- I am postmenopausal  Yes  No  Don't know
- I am pregnant  Yes  No  Don't know
- I have had a hysterectomy  Yes  No  Don't know
- I use an IUD  Yes  No  Don't know

\_\_\_\_\_  
 Patient Signature