

VinCon Diagnostic Center

5732 Canton Cove Winter Springs, FL 32708

Today's date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Ultrasound Questionnaire

Please fill out following information pertaining to your test today:

- Penile**
- Testicle(s)** **Right** **Left** **Bilateral**
- Prostate**

Why is this exam being performed? _____

Do you have any symptoms? No Yes
If yes, When did they begin? _____

Do you have or have you had Fever? No Yes, how long have you had fever? _____

Have you had this problem before? No Yes

Have you been treated for this problem before? No Yes
If yes, When? _____

What type of treatment did you receive? _____

Have you had any prior imaging to this body part / area? No Yes

Do you have a personal history OR family history of cancer? No Yes

If Yes, what type of cancer? _____
How long ago? _____ How long in remission? _____

Related to injury/trauma? ___ No ___ Yes
If Yes, What is the Date of injury/trauma: ____/____/____
What date did your symptom(s) begin? ____/____/____

Please check all that apply:

- Pain Fever Swelling Palpable lump
- Abnormal lab report (Elevated PSA)
- Injury? Please explain: _____

TECHNOLOGIST ONLY: _____

