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Patient Questionnaire- Venous Doppler

1. Name: ________________________________ Date: ____/____/____
2. Date of birth: ____/____/____ Height: __________ Weight: _____
3. Are you currently taking any medications? ( ) Yes ( ) No
   If yes, what type of medication: ______________________________________
   ____
   ____
4. Do you have leg pain? ( ) Yes ( ) No ( ) Left side ( ) Right side ( ) Both sides
   If yes, how long have you had this pain? ________________________
5. Have you ever had a DVT? ( ) Yes ( ) No
   If yes, when? ____________________________
6. Have you ever had an ultrasound done before? ( ) Yes ( ) No
   If yes, when and where? ______________________________________
7. Is there anything you would like to disclose to the sonographer before the procedure?
   ____
   ____
   ____

Patient Signature: ________________________________ Date: ____/____/____