Inland Empire Imaging Center
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Patient Questionnaire- Scrotal

1. Name: _____ Date: ___/___/____
2. Date of Birth:___/___/_____ Height: _____Weight: _____
3. When was the last time you ate?_____
4. Are you currently taking any medication? ( ) Yes ( ) No
   If so, what type of medication: _____
   _____
   _____
   _____
5. Do you have pain in your scrotum? ( ) Yes ( ) No
   If yes, how long have you had this pain? _____
   Where is the pain located? _____
6. Do you smoke? ( ) Yes ( ) No If yes, how many packs a day? _____
7. Do you consume alcohol? ( ) Yes ( ) No
8. Have you had any previous surgery on your abdomen? ( ) Yes ( ) No
   If yes, when? _____
9. Are you diabetic? ( ) Yes ( ) No
10. Have you had an ultrasound done before? ( ) Yes ( ) No
    If yes, when and where? _____
11. Is there anything you need to disclose to the sonographer before the procedure? _____
    _____
    _____
    _____

Patient Signature: _____ Date: ____/____/____