Inland Empire Imaging Center
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Patient Questionnaire- Testicular

1. Name: _____ Date: ___/___/____

2. Date of Birth: ___/___/___ Height: _____ Weight: _____

3. Are you currently taking any medication? ( ) Yes ( ) No
If yes, what type of medication? _____
_____
_____
_____

5. Do you have testicular pain? ( ) Yes ( ) No ( ) Right side ( ) Left side ( ) Both sides

If yes, how long have you had this pain? _____

7. Have you ever had testicular torsion? ( ) Yes ( ) No

8. Have you had previous surgery on your lower abdomen or pelvic area? ( ) Yes ( ) No
If yes, when? _____

9. Have you had an ultrasound done before? ( ) Yes ( ) No
If yes, when and where? _____

10. Is there anything you need to disclose to the sonographer before the procedure? _____
_____
_____

Patient Signature: _____ Date: ____/____/____