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NON-INJURY/CHIEF COMPLAINT - ULTRASOUND

Patient Name:_____ Date:_____

Is this the first time we are seeing you for this problem? Yes_ ___ No_ __

If no, last visit date_____

What symptoms are you having?

_____

When did you first experience the symptoms? Please be as specific as possible.

_____

Are the symptoms constant or intermittent (off and on)?

_____

How long do the symptoms last?

_____

Is there a particular side that hurts more than the other?

_____

Signature_____ Date_____