

GENERAL SOFT TISSUE

NAME _____ AGE _____ TODAY'S DATE _____

1. WHY ARE YOU HAVING THIS TEST? _____

2. DO YOU HAVE ANY PAIN? _____ WHERE? _____

3. DID YOU OR DOCTOR FEEL A MASS OR LUMP? _____

4. DID YOU HAVE ANY OTHER TEST RELATED TO THIS PROBLEM? _____

5. IF YES, WHERE AND WHEN? _____

6. ANY OTHER INFORMATION THAT MIGHT BE HELPFUL? _____

SONOGRAPHER'S COMMENTS _____
