EISENHOWER
IMAGING CENTER

Carotid Ultrasound

Guest Name: _____ Date: _____

Medical Record Number: _____

Previous Carotid Imaging ☐ Yes ☐ No

If yes, what type: _____

_____

Previous Carotid Surgery ☐ Yes ☐ No

If yes, what side: ☐ Right ☐ Left ☐ Both

Current Symptoms: _____

_____

_____

_____

Check all that apply:

☐ High Blood Pressure ☐ High Cholesterol

☐ Diabetes ☐ History of Previous Stroke

☐ Smoker

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