EISENHOWER
IMAGING CENTER

Scrotal (Testicle) Ultrasound

Guest Name:_____ Date: _____

Medical Record Number:_____

Previous Scrotal Imaging: ☐ Yes ☐ No

If yes, what type: _____

_____

Previous Scrotal Surgery: ☐ Yes ☐ No

If yes, what type: _____

_____

History of cancer: ☐ Yes ☐ No

If yes, what type: _____

_____

Previous scrotal infections: ☐ Yes ☐ No

If yes, when/what type: _____

_____

Have you had a vasectomy ☐ Yes ☐ No

Current Symptoms: _____

_____

_____

_____

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