THUMB REGION
1100 S. Van Dyke • Bad Axe, Michigan 48413
989-269-9521 • Fax: 989-269-7948 • www.huronmedicalcenter.org

OB ULTRASOUND 1ST TRIMESTER

Name: ______________________________ X-Ray #: ______________________

Referring Physician: ______________________ EDC: ______________________

Date: ______ LMP: ______ Age: _____ G: ____ P: ____ Ab < 20 wks _____ Ab > 20 wks _____

Pelvic Exam: ______________ Surgeries/C-Sections: ______________________

High Blood Pressure: __________ Diabetes: ______________________________

Bleeding/Spotting/Discharge: ________________ Hormones: ________________

Indication: ______________________ Transducer Freq.: ________________

Gestation:
( ) Single
( ) Twin
( ) Other

Presentation:
( ) Vertex
( ) Breech
( ) Oblique
( ) Transverse
( ) Unstable

Fetal Activity:

Yes	No	
( )	( )	Limb
( )	( )	Heart ______ Heart Rate

Gestational Sac Size: ______________ CM ______________________ wks

CRL: ______________ CM ______________________ wks

Yolk Sac: ______________________

Amniotic Fluid:
( ) Normal
( ) Oligohydramnios
( ) Polyhydramnios

Placenta:
( ) Anterior
( ) Fundal
( ) Posterior
( ) Rt. Lateral
( ) Lt. Lateral
( ) Previa
( ) Marginal
( ) Partial ________ %
( ) Total

Sonographer's Impression: ____
____
____

Previous Scans:

Date: EDC:

1. ______________________________
2. ______________________________

Cervix: ______________________
EDC by US: ______________________
GA by US: ______________________

Diagnosis After Scan/ Comments: ____
____
____

Radiologist Signature: ______________________________