THUMB REGION

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 ( ) Transverse
( ) Breech ( ) Unstable
( ) Oblique

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 ( ) Rt. Lateral ( ) Marginal
( ) Fundal ( ) Lt. Lateral ( ) Partial ______%
( ) Posterior ( ) Previa ( ) Total

Sonographer's Impression: ____

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Previous Scans:

Date: EDC:

1. ______________________ Cervix: ______________________
2. ______________________ EDC by US: ______________________

GA by US: ______________________

Diagnosis After Scan/ Comments: ____

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Radiologist Signature: ______________________

7200.106.03-02