McLaren

CARO REGION

ULTRASOUND WORKSHEET FIRST TRIMESTER

Name:_____ MR#:_____

Date:_____Physician:_____

OBSTETRIC HISTORY Gravida:_____ Para:_____ AB:_____ Miscarriage:_____

Diabetes: ☐ Yes ☐ No Reason for exam:_____

HTN: ☐ Yes ☐ No _____

Bleeding: ☐ Yes ☐ No _____

FETAL AGE BASED ON:

LMP:__/__/__ Normal____ Abnormal____ Sure____ Unsure___ LMP:_____

EDC:__/__/__ EDC:_____

Prev. US:__/__/__ Prev. US:_____

Current US:_____

FIRST TRIMESTER:

# of sacs:_____ Gestation sac size____x____x____cm Correlates to: ____ wks____d

CRL:_____cm Correlates to :_____wks_____d

Normal yolk sac seen: ☐Yes ☐No

FHT: ☐ Yes_____BPM

☐ No

MATERNAL:

Uterus: Sag: _____x_____x_____cm ☐Normal ☐Abnormal

Right Ovary: _____x_____x_____cm Comments:_____

Left Ovary : _____x_____x_____cm Comments:_____

Free Fluid: ☐Yes ☐ No

COMMENTS:_____

_____

_____

_____

_____

_____

_____Sonographer:_____

FORM: US 16
NEW: 11-20-19