McLaren
CARO REGION

GYN ULTRASOUND

NAME: _____ DATE: _____

AGE: _____ MR# _____ DR. _____

Pregnancies: _____ Miscarriages: _____ Living Children: _____

Deliveries: _____ Abortions: _____

Reason for this ultrasound study (complaint): _____

Date of last menstrual period (first day of period): _____ Regular cycles? Yes No

Previous pelvic surgery:
Yes No _____
Please describe

Previous gynecological problems:
Yes No _____
Please describe

Do you use any type of birth control? Yes No If yes, please give type: _____

Are you being treated for, or been told you have: OVARIAN CYSTS FIBROID

Are you currently having?
PELVIC PAIN: Yes No If yes, where: _____

ABNORMAL VAG. DISCHARGE: Yes No FEVER Yes No

General medical problems:
Yes No _____
Please describe

UTERUS: SAG _____ cm AP _____ cm TRV _____ cm Normal Abnormal

Endometrial Canal: Normal Abnormal Thickness: _____ cm

RIGHT OVARY:
L _____ X H _____ X W _____ Normal Abnormal RI:_____

LEFT OVARY:
L _____ X H _____ X W _____ Normal Abnormal RI:_____

Cul de sac fluid: Yes No

Comments: _____

_____

_____

_____

_____

Sonographer: _____ Date: _____

FORM: US 2
REV: 10-3-19