BERGEN
IMAGING CENTER, P.A.
WOMEN'S IMAGING SPECIALISTS OF ENGLEWOOD

180 NORTH DEAN STREET • ENGLEWOOD, NJ 07631
TEL: 201.568.4242 • FAX: 201.568.1298
WWW.BERGENIMAGINGCENTER.COM
CHRISTOPHER L. PETTI, MD
ACCREDITED BY THE AMERICAN COLLEGE OF RADIOLOGY

Account # _____ Today's Date _____
(to be completed by Receptionist)

Name: Last _____ First _____

Date of Birth _____ Age_____

Type of Ultrasound: _____

Send report to the following Physician: _____

_____

_____

Are you pregnant? ☐ YES ☐ NO

What is the reason for having this exam? _____

Previous Pelvic Ultrasounds? Where and when_____

Date of last menstrual period:_____

Date of last Gynecological Examination: _____

History of Abdominal or Pelvic surgery: _____

Personal history of Gynecological Cancer?: _____

Family history of Gynecological Cancer?: _____

Do you have any intrauterine contraceptive devices? _____

List current medications & hormone replacement therapy, and date started:

_____

_____

Do you take Tamoxifen?: ☐ YES ☐ NO

I verify that the answers I have provided to the questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patient's signature _____ Date: ___/___ /

NOTE: If you have previous films and/or reports with you, please give them to the receptionist before your exam.