PELVIC ULTRASOUND REGISTRATION FORM

TECHNICIAN INITIALS

US: □ JD □ EM □ DB

Account #: _______________ Today's Date: ________________

Name: Last ____________________________________ First: ______________________________________

Date of Birth: _________________________ Age: ___________________

Send report to the following Physician: ____

Are you pregnant? □ Yes □ No How many full-term pregnancies have you had? ________________________

What is the reason for this exam? ____

Have you had previous radiology studies? Where and when? ____

First day of last menstrual period? ____

Date of last gynecological examination? ____

History of abdominal or pelvic surgery including c-section(s)? ____

Personal history of gynecological cancer? ____

Family history of gynecological cancer? ____

Do you have an intrauterine contraceptive device? ____

If yes, please specify type/brand: ____

Do you take oral contraceptives? If yes, please specify. ____

Personal history of pelvic medical conditions (i.e., PCOS, endometriosis, etc.): ________________________________

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

____

____

Do you take Tamoxifen? □ Yes □ No Are you allergic to **LATEX**? □ 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 discs and/or reports with you, please give them to the receptionist upon check-in.