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

PELVIC ULTRASOUND REGISTRATION FORM

TECHNICIAN INITIALS

US: □ JD □ DH □ 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.