ULTRASOUND

Patient Name:______________________________Date of Birth: _______/_______/_______

Weight:________________Height:_______________

YES **NO**

❑ ❑ Have you had a Cough, Fever, or any Flu-like symptoms within the past 2 weeks?

❑ ❑ Have you recently come into contact with anyone who was COVID positive?

❑ ❑ Any recent travels outside of the USA?

Have you had an Ultrasound before? ❑YES ❑NO
If YES: When: ________________ Where: ________________ What type: _____________

Why are you having this Ultrasound today? ____

____

Any Pain? ❑YES ❑NO For how Long? ______________________________________

List Previous Surgeries: ____

Female Patients Only:

Are you pregnant? ❑YES ❑NO **First** day of last menstrual period: ____/____/______

Number of Pregnancies: ________ Number of Abortions/Miscarriages: ________

Number of live births: ________ Number of Ectopic pregnancies: ________

Are you having Pelvic Pain? ❑YES ❑NO For how long? __________________

Any abnormal bleeding? ❑YES ❑NO For how long? __________________

Hysterectomy? ❑YES ❑NO Ovaries Removed? ❑YES ❑NO Right / Left

Are you on any hormone replacement? ❑YES ❑NO

Form of birth control currently using: ___________________________________

I attest that the above information provided by me is correct to the best of my knowledge. I have read and understood the entire content of this form and I have had the opportunity to ask any unclear issue in this regard.

►Signature: ____Date: ______/______/_______

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