Pelvic (Non-OB) Ultrasound Worksheet

Patient Name: _____ **MR#:** _____ **Date:** _____/_____/_____

Referring Physician: _____ **Tech:** _____ **Chaperone:** _____

Reason for Study: _____

Patient History: _____

_____

TRANSABDOMINAL ☐ **TRANSVAGINAL** ☐

LMP: _____/_____/_____ **Post-Menopausal** ☐ **Gravida:** _____ **Para:** _____ **AB:** _____ **Ectopic:** _____

Hormone Therapy ☐ **Birth Control:** Pills ☐ Depo Shot ☐ IUD ☐ Implant ☐ NuvaRing ☐

Hx of C-Section ☐ **Hysterectomy:** Total ☐ Partial ☐ **Oophorectomy:** Right ☐ Left ☐

U T E R U S: Anteverted / Anteflexion ☐ Retroverted / Retroflexion ☐ Straight ☐ **Surgically Absent** ☐

Shape: Normal ☐ Bicornuate ☐ Didelphys ☐ Other ☐: _____

UT Dimensions: _____ x _____ x _____ cm Volume: _____ mL

Fibroids ☐ ***If so, are there multiple?*** No ☐ Yes ☐ Largest: _____ x _____ x _____ cm

Uterine Findings:

_____

_____

C U L - D E - S A C:

_____

_____

E N D O M E T R I U M: _____ mm **C E R V I X:** **Surgically Absent** ☐

Fluid ☐ Masses ☐

Endometrial Findings:

_____

_____

Fluid ☐ Masses ☐

Cervical Findings:

_____

_____

V A G I N A:

_____

_____

R I G H T O V A R Y: _____ x _____ x _____ cm Volume: _____ mL _____ ☐

Cysts ☐ ***If so, are there multiple?*** No ☐ Yes ☐ Largest: _____ x _____ x _____ cm

Vascularity seen: No ☐ Yes ☐

Right Ovarian Findings:

_____

_____

R I G H T A D N E X A:

_____

_____

L E F T O V A R Y: _____ x _____ x _____ cm Volume: _____ mL _____ ☐

Cysts ☐ ***If so, are there multiple?*** No ☐ Yes ☐ Largest: _____ x _____ x _____ cm

Vascularity seen: No ☐ Yes ☐

Left Ovarian Findings:

_____

_____

L E F T A D N E X A:

_____

_____

Comments: _____