

Ultrasound Test Form



Date: _____

Patient Name: _____ MRN _____

Please answer these questions accurately to help the doctor get the most information from your ultrasound examination.

When did your last menstrual period begin? (Date): ____ / ____ / ____

If you have stopped having menstrual periods, please answer the following:

Has your uterus been removed?	Yes / No
Have you been through menopause?	Yes / No
If yes, do you take hormone medications?	Yes / No

If you are still menstruating, please answer the following:

Do you use birth control pills?	Yes / No
Do you use an IUD?	Yes / No
Are you pregnant?	Yes / No / Unsure

If yes or unsure, please answer:

When was your last pregnancy test? (Date): ____ / ____ / ____	
What type of test was performed?	Blood / Urine / Other
The test was:	Positive / Negative

All patients please answer the following:

Do you have, or have you recently had, vaginal bleeding?	Yes / No
Do you have pelvic pain?	Left / Right / Both
Do you have cramping?	Yes / No
Do you have any other symptoms? _____	

Surgical History:

Have you had any operations on your female organs?	Yes / No
Has your uterus been removed?	Yes / No
Has your ovary been removed?	Left / Right / Both
Have you been treated for cancer of your female organs?	Yes / No