Women's Center For Radiology

ULTRASOUND TEST FORM

Please answer the following questions accurately to help your doctor get the most information possible:

PATIENT NAME _____ **DATE** _____

I still have menstrual cycles **Yes** ☐ **No** ☐

I have been through menopause **Yes** ☐ **No** ☐

If yes, do you take female hormone pills? Yes ☐ No ☐

My last menstrual period began on _____

My next scheduled physician's appointment _____

I have these symptoms:

I have, or have recently had, vaginal bleeding Yes ☐ No ☐

I have pelvic pain (Y/N) ____ If YES, which side? Left ☐ Right ☐ Both ☐

I have cramping Yes ☐ No ☐

I have other symptoms: _____

My surgical history:

I have had an operation on my female organs Yes ☐ No ☐

My uterus was removed Yes ☐ No ☐

If yes, when? _____

I have had an ovary removed Yes ☐ No ☐

If yes, LEFT ☐ RIGHT ☐ BOTH ☐

I have been treated for cancer for my female organs **Yes** ☐ **No** ☐

I am pregnant **Yes** ☐ **No** ☐

My last pregnancy test was on _____ Blood test? ☐ Urine test? ☐

The test was POSITIVE ☐ NEGATIVE ☐

I am currently using birth control pills Yes ☐ No ☐

I am currently using an IUD Yes ☐ No ☐