Early OB Ultrasound

Patient Name	Date of Exam
LNMP	Age by Dates
Gravida	Age by US Today
Para	Date of Prior US
History	
Pain _____ days _____weeks _____ months	Bleeding _____ days _____ weeks
Comments	

Fetal Pole: ☐ Yes ☐ No

Fetal Number: _____

Fetal Heart Rate: _____BPM

Fetal Yolk Sac: ☐ Yes ☐ No

Placenta: Location: _____ Bleed: ☐ Yes ☐ No Subchorionic Retrochorianic

Fluid: Posterior Cul de Sac Minimal Moderate Severe

Right Ovary	**Left Ovary**
_____ x _____ x _____ cm	_____ x _____ x _____ cm
Follicle/Cyst: _____ x _____ x _____ cm	Follicle/Cyst: _____ x _____ x _____ cm

Uterus: Anteverted Anteflexed Retroverted Retroflexed

CRL: _____cm Age: _____ wks

Gest Sac: _____X _____X _____ cm Age: _____weeks

Call Results ☐ Yes ☐ No	Physician Notified ☐ Yes ☐ No
Sonographer	