Patient Name	Date of Exam
History	
Trans Abdominal	**Trans Vaginal**
Ut. _____x_____x_____ cm	Ut. _____x_____x_____ cm
Endo. _____cm	Endo. _____cm
Fibroids 1. _____x_____x_____ cm	2. _____x_____x_____ cm
Rt. Ov. x x cm	Rt. Ov. _____x_____x_____ cm
Cyst 1. _____x_____x_____ cm	2. _____x_____x_____ cm
Doppler Flow Arterial Wave Form □ Yes □ No	Venous Wave Form □ Yes □ No
Lt. Ov. _____x_____x_____ cm	Lt. Ov. _____x_____x_____ cm
Cyst 1. _____x_____x_____ cm	2. _____x_____x_____ cm
Doppler Flow Arterial Wave Form: □ Yes □ No	Venous Wave Form: □ Yes □ No
Free Fluid: □ Yes □ No	
Comments	
Sonographer	Call Report: □ Yes □ No Physician Notified: □ Yes □ No