MEDICAL IMAGING ASSOCIATES

a radiology partners practice

Pelvic Ultrasound

Patient Name: _____ **Date:** _____

LMP: _____/Unknown G: _____ P: _____ A: _____

Indication: _____

Trans ABDOMINAL Exam

Uterus:

Size:_____x_____x_____ (cm) Position (circle): Anteverted Anteflexed Retroverted Retroflexed

Ovaries: **Right** **Left**

_____x_____x_____(cm) _____x_____x_____(cm)

Trans VAGINAL Exam

Uterus:

Size:_____x_____x_____ (cm) Position (circle): Anteverted Anteflexed Retroverted Retroflexed

Endometrial Stipe Thickness:_____(mm)

Ovaries: **Right** **Left**

_____x_____x_____(cm) _____x_____x_____(cm)

Cysts: _____ Cysts: _____

Ovarian Blood Flow: Right – Yes/No Left – Yes/No

Free Fluid: None / Small / Moderate / Large

Tech Notes:_____

_____

_____

_____

_____

Sonographer_____ **Chaperone:**_____