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ALL PELVIC ULTRASOUNDS
(NON-OB)

PATIENT NAME: _____ **DOB** _____

DATE OF EXAM: _____

1. WHY ARE YOU HAVING THIS TEST TODAY? _____

2. WHEN WAS YOUR LAST MENSTRUAL PERIOD? _____

3. PLEASE LIST ANY PREVIOUS PELVIC SURGERIES AND DATES:

FOR OFFICE USE ONLY:

IMPRESSIONS:

