OB 1ST TRIMESTER ULTRASOUND

☐ Transabdominal ☐ Transvaginal

Name: _____ Date: _____

Physician: _____ DOB: ____/____/_____ Age: _____

Sonographer: _____

Clinical Indications: _____

LMP: _____ Quantitative hCG: _____

Gest. Age BY LMP: _____wks _____ days by US: _____wks _____ days

VISUALIZED:	GESTATIONS	NONE	SINGLE	MULTIPLE_____
	GESTATIONAL SAC	YES	NO	_____ CM
	YOLK SAC	YES	NO	_____ CM
	EMBRYONIC POLE	YES	NO	_____ CM
	CARDIAC ACTIVITY	YES	NO	_____ BPM
	Free Fluid	YES	NO	
	ADNEXA	NORMAL	ABNORMAL	RT LT

Uterus: _____ cm (length) _____ cm (AP) _____ cm (trans)

_____

Rt Ovary: _____ cm (length) _____ cm (AP) _____ cm (trans)

_____

Lt. Ovary: _____ cm (length) _____ cm (AP) _____ cm (trans)

_____

Additional Comments: _____

_____