Obstetrical Ultrasound Questionnaire

Patients Name: ______________________________ DOB: _____ /_____ /______

Estimated Due Date: ______________________________

Date of Last Menstrual Cycle: ______________________________

Have you had a recent Pregnancy Test: ☐ Yes ☐ No If so, what type: ☐ Blood ☐ Urine

Number of pregnancies, including this one:______________________________

Number of Miscarriages/Abortions (if any): ______________________________

Number of Complete pregnancies: ______________________________

Method of Delivery: ☐ Vaginal Birth ☐ C-Section

Do you have Abdominal/Pelvic Pain: ☐ Yes ☐ No

Are you Diabetic: ☐ Yes ☐ No

Do you smoke: ☐ Yes ☐ No

Are you currently taking any Medications, including Contraceptives: ☐ Yes ☐ No

If so, what kind: ______________________________

Are you bleeding: ☐ Yes ☐ No

If so, please explain: ______________________________

Is there a family history of birth defects: ☐ Yes ☐ No

If so, please explain: ______________________________

Have you ever taken Infertility Drugs: ☐ Yes ☐ No

If so, when: ______________________________

Have you had a previous Ultrasound for this pregnancy: ☐ Yes ☐ No

If so, where: ______________________________

This exam may require a Transvaginal examination which allows very close and clear images for better results. The examination is performed by sonographers who are health professionals and accredited to perform the exam. If you have further questions, please inform the Receptionist.

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