DIAGNOSTIC RADIOLOGY CENTER OF THE TREASURE COAST, INC.

AJAY K. GOYAL,M.D.,BOARD CERTIFIED RADIOLOGIST

ULTRASOUND SCREENING FORM
PELVIC EXAM

PLEASE PROVIDE THE FOLLOWING INFORMATION. (PRINT CLEARLY)

NAME____ DATE___________________

DOB_________________ AGE _________________

REFERRING PHYSICIAN____

REASON FOR EXAM (SYMPTOMS) ______________________________________

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WHEN DID SYMPTOMS FIRST BEGIN?___________________________________

SURGICAL HISTORY ____

____

PREVIOUS RADIOLOGY/ULTRASOUND STUDIES
____

1ST DAY OF LAST MENSTRAL PERIOD ________________________________

POST MENOPAUSAL? YES NO
IF YES HORMONE REPLACMENT THERAPY? YES NO

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? PLEASE CIRCLE

CYSTS MASS FIBROID CANCER HYSTERECTOMY POLYPS

ABNORMAL BLEEDING IRREGULAR PERIODS PELVIC PAIN

IF YES TO ANY PLEASE EXPLAIN_______________________________________
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