DIAGNOSTIC RADIOLOGY CENTER OF THE TREASURE COAST, INC.

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

ULTRASOUND SCREENING FORM
OBESTETRICAL/BIOPHYSICAL PROFILE

PLEASE PROVIDE THE FOLLOWING INFORMATION. (PRINT CLEARLY)

NAME_____ DATE_____

DOB_____ AGE _____

REFERRING PHYSICIAN_____

PREVIOUS ULTRASOUND STUDIES ON THIS PREGNANCY? YES NO
IF YES WHERE AND WHEN?_____

1ST DAY OF LAST MENSTRAL PERIOD _____

HOW MANY WEEKS PREGNANT ARE YOU?_____

ARE YOU CURRENTLY EXPERIANCING ANY PROBLEMS WITH THIS PREGNANCY? YES NO

IF YES PLEASE EXPLAIN
_____
_____
_____

NUMBER OF TIMES YOU HAVE BEEN PREGNANT ?_____
HOW MANY HAVE YOU CARRIED TO TERM? _____

HAVE YOU EVER HAD AN ECTOPIC PREGNANCY? YES NO