

CARNEGIE IMAGING FOR WOMEN

THE LEADING EDGE
IN WOMEN'S HEALTH

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ULTRASOUND PATIENT QUESTIONNAIRE

PLEASE COMPLETE THE FOLLOWING: Height: _____ Weight: _____

Name: _____ Date of Appointment: _____

Name of Doctor's Group: _____

Name of your Doctor: _____

Race/Ethnic Background: Asian African American Caucasian Hispanic Other _____

First day of your last menstrual period: _____ Due Date: _____

Are your menstrual cycles: Regular Irregular _____ # of days between cycles

Did you have a first trimester screening or a Quad screen blood test to screen for Down Syndrome or spinal defects?

Yes No If yes, was it normal? Yes No Not Sure

Why did your doctor want to have an ultrasound exam today? _____

OBSTETRICAL HISTORY:

How many children have you had? _____

How many pregnancy losses or miscarriages have you had? _____

If you had pregnancy losses, did any of them occur between 22 and 37 weeks gestation?

Yes No If yes, how many? _____

Was your current pregnancy achieved via in vitro fertilization? Yes No

Were any of your deliveries by Cesarean section? Yes No If yes, how many? _____

Have you ever been pregnant with a child that had a birth defect or chromosomal abnormalities? Please explain: _____

Have you experienced any complications with previous pregnancies? Please Explain: _____

Have you experienced any complications with this pregnancy? _____

Do you have any medical problems (example: diabetes, high blood pressure, heart disease, abnormal pap smears, DES exposure,

Cone biopsy? Please Explain: _____
