MEDICAL IMAGING OF MANHATTAN, LLC

Account #: _____ Technician: _____ Date: _____

Pelvic/Transvaginal Imaging Worksheet

Name: _____ Age: _____ Date of Birth: _____

Date of Last Menstrual Period: _____

Are you Pregnant? (Please circle) No/Yes If Yes, how many weeks? _____

Most recent Pelvic/TV Exam: When? _____ Where? _____

Reason for today's exam: (Routine / Follow-up / Medical problem or Complaint):

_____

_____

List previous surgeries: _____

_____

_____

List Current Medications (including hormones, birth control, etc):

_____

_____

Is there a family history of ovarian cancer? (Please circle) No/Yes

If yes, please explain:

_____

_____

IF YOU HAVE BROUGHT PREVIOUS FILMS OR REPORTS WITH YOU, PLEASE GIVE THEM TO THE RECEPTIONIST BEFORE YOUR EXAM.