CARNEGIE IMAGING
The Leading Edge in Women's Ultrasound

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NEW ULTRASOUND PATIENT–MEDICAL HISTORY

Name: _____ **Appt Date:** _____

Referring Doctor's Name: : _____

OBSTETRICAL PATIENTS – PLEASE COMPLETE THE FOLLOWING:

Height: _____ **Pre-pregnancy Weight:** _____ **1st day of last period:** _____ **Due Date:** _____

How many times have you been pregnant? _____ **How many living children do you have?** _____

#Full term births (>37 weeks) _____ **# Preterm births (<37 weeks)** _____

 # Miscarriages (<20 weeks)) _____ **# Abortions** _____

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

If yes: date of transfer: _____ Age of embryo at transfer (ex. 5 days)**:** _____ PGS/PGD**:** ☐ **Yes** ☐ **No**

Donor egg: ☐ **Yes** ☐ **No** **Frozen egg/embryo:** ☐ **Yes** ☐ **No** **If yes,** age of egg: _____

Have you ever been pregnant with a child that had a birth defect or genetic abnormalities? If yes, please explain: _____

_____

Have you had any complications with prior pregnancies: _____

Have you ever had any surgeries on your uterus, cervix, or ovaries (for example: Cesarean section, removal of fibroids, LEEP)? If yes, please explain: _____

Will you be 35 or older at the time of your due date? ☐ **Yes** ☐ **No**

Do you have any medical problems (such as diabetes, high blood pressure, asthma, lupus)? If yes, please explain: _____

Please list any medications you take (including supplements)? _____

Is this a twin, triplet, or quadruplet pregnancy? ☐ **Yes** ☐ **No**

GYNECOLOGIC PATIENTS – PLEASE COMPLETE THE FOLLOWING:

1st day of last period: _____

Have you ever had any surgeries on your uterus, cervix, or ovaries (for example: hysterectomy, ovarian cyst removal, LEEP)? If yes, please explain:

_____

Do you take any medications or have an IUD in place? _____

Why did your doctor want you to have an ultrasound exam done today (for example: irregular bleeding, pain, fibroids, ovarian cysts, infertility)?

_____