



**PERINATAL ULTRASOUND DIAGNOSTIC WORKSHEET**

**Completed by Patient:**

Today's Date: \_\_\_\_\_ Your Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (MI)

Expected Date of Delivery (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

First Day of Last Normal Menstrual Period (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

Date of Conception or Retrieval (if known) (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

Date of Transfer (if applicable) (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Pre-pregnancy Weight: \_\_\_\_\_

Your Blood Type (for procedures only): \_\_\_\_\_

**Past Pregnancies:**

# of Full-term Pregnancies \_\_\_\_\_ # of Miscarriages \_\_\_\_\_ # of Terminations \_\_\_\_\_

# of Premature Births \_\_\_\_\_ # of Ectopic Pregnancies \_\_\_\_\_ # Stillbirths \_\_\_\_\_

# of Living Children \_\_\_\_\_

**Please check all that apply for current pregnancy:**

IVF  ICSI  IUI  Donor Egg (Age of Donor: \_\_\_\_\_)

Clomid  Gonadotropin Injection (Follistim, Pergonal, etc.)  PGD

Heparin (Lovenox, Fragmin, heparin—circle one)  Baby aspirin  Progesterone

Other: \_\_\_\_\_

None of the above

Patient's Signature: \_\_\_\_\_

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**Sonographer Use Only**