Mount Sinai Doctors

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: _____

Sonographer Use Only