BROWN-FOLSE PACS, LLC
PELVIC ULTRASOUND INFORMATION SHEET

PATIENT_____DATE_____

PT #_____DOB_____

DX/HX_____

LMP_____ G_____ P_____ A_____

PREV. SURG._____

UTERUS_____

_____

ENDOMETRIUM_____

CERVIX_____

RT OVARY_____

_____

LT OVARY_____

_____

COMMENTS: _____

_____

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_____

SONOGRAPHER_____