Center For
WOMEN'S HEALTH & WELLNESS

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Pelvic Ultrasound Worksheet

Name: _____ Date: _____/_____/_____ ID: _____
DOB: _____/_____/_____ AGE: _____ Referring Physician: _____
Indications: _____ TECH: _____
Height: _____ Weight: _____ LMP: _____/_____/_____ G___ P___ M___ P___
HRT/BCP: YES/NO _____
Previous Surgery: _____

⬜Transvaginal Imaging Performed

Uterus: _____ x _____ x _____cm ⬜Nabothian Cyst(s)
Endometrium: _____cm

Masses/Fibroids:	Measurements	Location	Description
1.	x x cm		
2.	x x cm		
3.	x x cm		
4.	x x cm		

Cul-de-sac Fluid: TRACE MINIMUM MODERATE SEVERE

Right Ovary: _____ x _____ x _____cm
o Simple Cyst o Complex Cyst(s) o Mass o Other

Left Ovary: _____ x _____ x _____cm
o Simple Cyst o Complex Cyst(s) o Mass o Other

Comments:

_____

_____

_____

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