Arlene Weinshelbaum, M.D.
Pelvic Ultrasound History

Please complete and bring with you. **Appointment Date:** _____

Name _____ Date of Birth _____ Age _____

Address _____
(street) (city) (zipcode)

Your Employer _____ Business Telephone _____

Social Security Number _____ Home Phone _____

Husband's Name _____ Married ____ Single _____ Divorced ___ Widow _____

Referred by Dr. _____ Address _____

List any other doctors you want a report to go to: _____

_____

Medical Information

Have you ever had a pelvic ultrasound in our office? _____

Last Menstrual Period: _____ Was it regular? _____

Any abnormal bleeding or discharge? _____

Pelvic exam or pap test? _____ Results _____

Pregnancy test? _____ Results _____

History of pelvic infections? _____ Ovarian Cysts? _____

Fibroids? _____ Any Pain? _____ Location: _____

Duration of Pain? _____

Previous Surgery? _____

Additional History _____

_____

_____

_____

_____

It is our policy that office visits be paid at time of services rendered. Please indicate how you would like to handle payment.

_____ check _____ cash _____ charge card