SOUMA DIAGNOSTICS
GYNECOLOGIC HISTORY

DATE: Month _____ Day _____ Year _____
NAME: First _____ Last _____
Date of birth: Month _____ Day _____ Year _____ Age: ____
Social security number: ____ - _____ - _____
Reason for scan: _____

Referring Health Care Professional: _____

Please answer this brief history to help us interpret the ultrasound findings

Date of previous ultrasound, if any? _____

First date of last menstrual period _____

Please circle correct answer

Has the uterus been surgically removed? YES NO

Comment _____

Has your right ovary been surgically removed? YES NO

Comment _____

Has your left ovary been surgically removed? YES NO

Comment _____

Nature of periods: NORMAL IRREGULAR HEAVY

Are you on any hormones ore medications?

Comment, if any: _____

Birth control pills: YES NO

Estrogen & Provera: YES NO

Estrogen only: YES NO

Tamoxifen: YES NO

Mirena IUD: YES NO

Other: Please discuss with your physician.

Level of CA125

If recently done: NORMAL ABNORMAL N/A

SOUMA DIAGNOSTICS

PATIENT REGISTRATION FORM

PATIENT REGISTRATION INFORMATION

LAST NAME FIRST NAME MIDDLE

STREET ADDRESS

CITY ST ZIP

DOB S.S.#

HOME PHONE # WORK PHONE #

EMPLOYER POSITION

EMPLOYER STREET ADDRESS

CITY ST ZIP

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME PHONE #

INS. CO. STREET ADDRESS CITY, ST ZIP

POLICY HOLDER'S NAME

ID# GROUP#

PATIENT REGISTRATION INFORMATION

LAST NAME FIRST NAME MIDDLE

STREET ADDRESS

CITY ST ZIP

DOB S.S.#

HOME PHONE # WORK PHONE #

EMPLOYER POSITION

EMPLOYER STREET ADDRESS

CITY ST ZIP

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME PHONE #

INS. CO. STREET ADDRESS CITY, ST ZIP

POLICY HOLDER'S NAME

ID# GROUP#

Have you ever had an ultrasound performed by SOUMA DIAGNOSTICS? **YES** **NO**

Your insurance is a method to receive reimbursement for services you have received. Having insurance is not a substitution for payment. Many companies have fixed payments or percentage of a fixed fee schedule based on your contract with them. Our office will assist you in getting maximum reimbursement from your insurance company, but you are responsible for the total amount due for services rendered to you, unless covered by your insurance carrier. Deductibles, co-insurance, and amounts not covered or considered above usual and customary by your insurance carrier is your responsibility.

I authorize and request the release of my medical information necessary to process my medical insurance claims. I also assign all medical benefits payable to SOUMA DIAGNOSTICS. This assignment will remain in effect until revoked by me in writing.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

SOUMA DIAGNOSTICS
OBSTETRIC HISTORY

DATE: Month _____ Day _____ Year _____
NAME: First _____ Last _____
Date of birth: Month _____ Day _____ Year _____ Age: ____
Social security number: ____ - _____ - _____
Reason for scan: _____

Referring Health Care Professional: _____

Please answer this obstetric history to help us better interpret the ultrasound findings

First date of last menstrual period Month _____ Day _____ Year _____

Number of pregnancies including this one _____ Number of living children _____ Number of miscarriage/s if any _____

Please circle correct answer				***Comment, if applicable***
Do you **frequently** have long intervals of 32-40 days between periods?	Yes	No	N/A	
Is this pregnancy a result of assisted "technology" (clomid, IVF, or other)?	Yes	No	N/A	Method is: _____
Did you have an early ultrasound to date the pregnancy (6-16 weeks?)	Yes	No	N/A	Expected date of delivery: _____
Have you had a first trimester fetal study to screen for chromosomal or other abnormalities?	Yes	No	N/A	Result? _____
Have you had a Multiple Marker genetic screen to assess the risk of a chromosomal abnormality?	Yes	No	N/A	Result? _____
Have you had a "United" screen to assess risk of a chromosomal abnormality?	Yes	No	N/A	Result? _____
Have you had an AFP screen to assess risk of spina bifida?	Yes	No	N/A	Result? _____
Have you had a CVS to check fetal chromosomes in this pregnancy?	Yes	No	N/A	Result? _____
Have you had amniocentesis to check fetal chromosomes in this pregnancy?	Yes	No	N/A	Result? _____
Have you had diabetes in any pregnancy including this one?	Yes	No	N/A	Insulin use: YES NO
Do you have any history of anatomic fetal abnormality?	Yes	No	N/A	Describe: _____
Do you have any history of chromosomal fetal abnormality?	Yes	No	N/A	Describe: _____
Do you have any history of delivering a large baby at term (greater than 8.5 pounds or 3800g)?	Yes	No	N/A	Weight? _____
Do you have a history of PRETERM delivery?	Yes	No	N/A	Delivery at _____ weeks
Have you had a previous C-section?	Yes	No	N/A	No. of C-sections _____

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