

## Uterine Fibroid Study Medical Record Sonography Form

Medical Record # _____	Date of Birth _____
Appt. Date ____ / ____ / ____ MO    DY    YR	Data from more than 1 report _____

Study ID#: UFS \_\_\_\_\_

FOR OFFICE USE ONLY

1. Abdominal U/S    Yes<sub>(1)</sub>    No<sub>(2)</sub>    2. Transvaginal U/S    Yes<sub>(1)</sub>    No<sub>(2)</sub>

2a. Indication: \_\_\_\_\_

Uterus

3a. Size: Length \_\_\_\_ . \_\_\_\_ cm X AP \_\_\_\_ . \_\_\_\_ cm X Width \_\_\_\_ . \_\_\_\_ cm

3b. Shape: Lobular    Yes<sub>(1)</sub>    No<sub>(2)</sub>

4. Diffuse heterogeneous pattern?    Yes<sub>(1)</sub>    No<sub>(2)</sub>

5. Focal fibroids    Yes<sub>(1)</sub>    No<sub>(2)</sub>

5e. Size of largest fibroid

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Comments: \_\_\_\_\_