Scrotal Ultrasound

Patient Name

DOB

MRN

Date _____

Provider _____

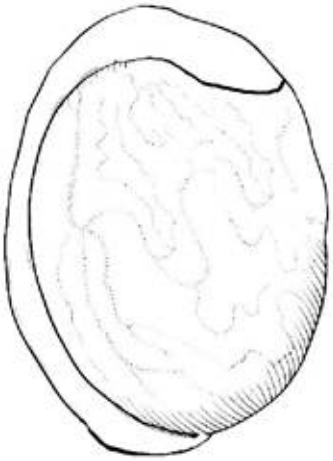
Tech _____

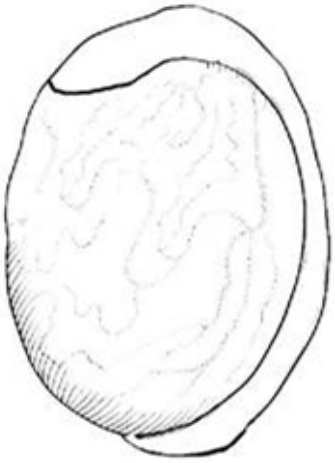
History: Pain ☐Y ☐N If yes onset: _____ ☐Sudden ☐Gradual On Antibiotics ☐Y ☐N

Palpable Mass ☐R ☐L Injury ☐R ☐L Undescended ☐R ☐L Fever ☐Y ☐N

Dysuria ☐Y ☐N ☐Other: _____

Surgical History: ☐Vasectomy ☐Other: _____





RIGHT TESTICLE _____ x _____ x _____ cm

Volume _____ ml

Location: ☐ Scrotal ☐ Inguinal

Homogenous? Yes No _____

Color Doppler Flow? absent normal ↑ ↓

Arterial Flow? Yes No N/A

Venous Flow? Yes No N/A

Masses? Yes No

Comments _____

_____

Hydrocele? Yes No _____

Varicocele? Yes No _____

Inguinal Hernia? Yes No _____

RIGHT EPIDIDYMIS

Color Doppler Flow: normal / increased

Masses? Yes No

Comments _____

_____

LEFT TESTICLE _____ x _____ x _____ cm

Volume _____ ml

Location: ☐ Scrotal ☐ Inguinal

Homogenous? Yes No _____

Color Doppler Flow? absent normal ↑ ↓

Arterial Flow? Yes No N/A

Venous Flow? Yes No N/A

Masses? Yes No

Comments _____

_____

Hydrocele? Yes No _____

Varicocele? Yes No _____

Inguinal Hernia? Yes No _____

LEFT EPIDIDYMIS

Color Doppler Flow: normal / increased

Masses? Yes No

Comments _____

_____