

US BLADDER

DATE: ___/___/___

TECH: _____

ID #: _____

PATIENT NAME: _____

DOB: ___/___/___

SEX: M / F

ACUTE HX (location, duration, severity) :

ACUTE HX (location, duration, severity) :

CHRONIC HX: _____

Diabetes HTN COPD CHF DVT

Smoking ETOH Obesity Renal Failure

Surgeries: _____

COMPARISON: YES · NO

DATE: _____

BLADDER	Normal	Suboptimal	Abnormal		Wall Thickness:
PRE-VOID VOLUME	Measured Volume: _____ mL				
POST-VOID VOLUME	Measured Volume: _____ mL				
OTHER					

Tech Summary:
