

(Office use)

MRI: GYNECOLOGIC QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____

PREMENOPAUSAL: _____ PERIMENOPAUSAL: _____

POSTMENOPAUSAL: _____ Number of Years: _____ Natural: _____ Surgical: _____

PRESENTING SYMPTOMS (Reason for today's examination): _____

GRAVITY (number of pregnancies): _____ PARITY (Number of deliveries): _____

MENSTRUAL HISTORY:

Last Menstrual Period (1 st day): _____	Age of 1 st menses: _____
Regularity of menstrual periods:	Regular cycles _____
	Irregular cycles: _____
Amount of bleeding: Mild (<2days): _____	
Moderate (3-7 days): _____	
Heavy (7 days): _____	
Painful menses: _____	

GYNECOLOGIC HISTORY:

Leiomyomas (Fibroids): _____	Ovarian Cysts: _____
Adenomyosis: _____	Endometriosis: _____
Endometrial polyps: _____	Infertility: _____
Pelvic Inflammatory Disease: _____	Chronic Pelvic Pain: _____
Ectopic Pregnancy: _____	Other: _____

HISTORY of CANCER:

Personal(Type): _____

Family History: _____
(1st or 2nd degree relative of: Ovarian, Breast, Endometrial, Colon)

SURGICAL HISTORY:

Hysterectomy: _____ (Total: _____ Supracervical: _____)

D&C: _____

Removal of ovary/ovaries: _____

Removal of ovarian cyst: _____

Myomectomy: _____

Cesarean Section: _____ Other: _____

MEDICATIONS:

Oral Contraceptives: _____ Premarin: _____	Hormone Replacement Therapy: _____
Depo-Provera: _____ Tamoxifen: _____	Lupron: _____
Ovarian Stimulation Medications: _____	Other: _____