

(Office use)

## ULTRASOUND: 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 <sup>st</sup> day): _____	Age of 1 <sup>st</sup> 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: \_\_\_\_\_  
(1<sup>st</sup> or 2<sup>nd</sup> 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: _____	Tamoxifen: _____
Premarin: _____	Depo-Provera: _____
Ovarian Stimulation Medications: _____	Lupron: _____
Hormone Replacement Therapy: _____	Other: _____