Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122

Please bring all completed forms to your appointment

(office use)

BIOPSY QUESTIONNAIRE

Print Name: _____ Date: _____ Age: _____

Weight: _____ Phone Number: _____

Procedure Scheduled: _____

Date of Procedure: _____

Referring Physician: _____

1. Is there any chance you could be pregnant? **Yes** **No**

2. Are you on a fertility protocol? **Yes** **No**

3. Date of last menstrual period: _____

4. Are you taking any medications? **Yes** **No**

If so, which? _____

5. Do you take Aspirin, Ibuprofen, Coumadin, or any other anticoagulants? **Yes** **No**

If so, which? _____

6. Do you have any medical conditions? **Yes** **No**

If so, which? _____

7. Do you have any blood clotting disorders? **Yes** **No**

If so, which? _____

8. Do you have a history of Myocardial Infarction (MI), angina, or arrhythmia? **Yes** **No**

9. Do you have any allergies to lidocaine, latex gloves, or adhesive tape? **Yes** **No**

If so, which? _____

10. Do you have any physical conditions which would present a difficulty to you for this procedure?

Yes **No**

Please explain: _____

_____

11. Additional precautions: _____

Questionnaire Completed By:

Print Name: _____ **Signature:**_____

Relationship to Patient: _____ **Date:** ____/_____/_____ **Time:** _____**AM/PM**

(FOR OFFICE USE ONLY) Questionnaire Completed By:

Print Name: _____**MD/RN/PA/TECH/**____

Signature:_____ **Date:** ____/_____/_____ **Time:** _____**AM/PM**