Weill Cornell Imaging

NewYork-Presbyterian | Weill Cornell Medicine

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*Please complete **MRI General Safety Form** in addition to this form*

(office use)

MRI: GYNECOLOGIC FORM

Name: _____ **Age**: _____ **Date**: _____

Presenting Symptoms (reason for today's examination):_____

_____

☐ **Premenopausal** ☐ **Perimenopausal** ☐ **Postmenopausal** (Number of years: ___ ☐ Natural ☐ Surgical)

Gravity (number of pregnancies): _____ **Parity** (number of deliveries): _____

MENSTRUAL HISTORY:

Last Menstrual Period (1st day): _____ Age of 1st menses: _____

Regularity of menstrual periods: ☐ Regular cycles ☐ Irregular cycles

Amount of bleeding: ☐ Mild (<2 days)
☐ Moderate (3-7 days)
☐ Heavy (7 days)
☐ Painful menses

GYNECOLOGIC HISTORY: (check all that apply)

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

HISTORY OF CANCER:

Personal (type): _____

Family History: _____

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

SURGICAL HISTORY: (check all that apply)

- ☐ Hysterectomy (Total: ____ Supracervical:____)
- ☐ D&C
- ☐ Removal of ovary/ovaries
- ☐ Removal of ovarian cyst
- ☐ Myomectomy
- ☐ Cesarean Section
- ☐ Other: _____

MEDICATIONS: (check all that apply)

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