Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine

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Please bring all completed forms to your appointment

(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 (1st day):_____ Age of 1st 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: _____