# 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: _____