Weill Cornell Imaging

NewYork-Presbyterian | Weill Cornell Medicine

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Please bring all completed forms to your appointment

(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 (1st day): ______________

Regularity of menstrual periods:

Age of 1st menses: _________

Regular cycles _________

Irregular cycles: _________

Amount of bleeding:

Mild (<2days): __________

Moderate (3-7 days): __________

Heavy (7 days): __________

Painful menses: __________

GYNECOLOGIC HISTORY:

Leiomyomas (Fibroids): ____________

Adenomyosis: ____________

Endometrial polyps: ____________

Pelvic Inflammatory Disease: ________

Ectopic 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:

Hysterectomy: _______ (Total: ______ Supracervical: ____)

D&C: _______________

Removal of ovary/ovaries: _________________

Removal of ovarian cyst: __________________

Myomectomy: _____________________________

Cesarean Section: ___________________________ Other: ____________________

MEDICATIONS:

Oral Contraceptives: _______

Premarin: _______

Ovarian Stimulation Medications: _______

Hormone Replacement Therapy: _______

Tamoxifen: _______

Depo-Provera: _______

Lupron: _______

Other: _________________________________