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)

ULTRASOUND:
GYNECOLOGIC QUESTIONNAIRE

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: _____

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ULTRASOUND:
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You are here for a sonographic (ultrasound) examination. Sonography uses sound waves to create images of the internal organs/tissues of your body.

Ultrasound is very safe. However, ultrasound imaging requires our technologists to place a probe directly in contact with the area that is being imaged. At Weill Cornell Imaging at NewYork-Presbyterian, we do offer chaperones for those patients who would feel more comfortable with having one in the room.

If you require any explanation about your examination or your visit to our practice, please ask any of our staff members or technologists. Your comfort is important to us and we want to address any questions and/or concerns you may have.

I authorize Weill Cornell Imaging at NewYork-Presbyterian, its physicians and other staff to perform the prescribed examination.

Questionnaire Completed By:

Print Name: _____

Signature: _____

Relationship to Patient: _____

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

The Patients' Bill of Rights is available for your review.

(FOR OFFICE USE ONLY)

Questionnaire Reviewed By:

Print Name (Full Name): _____ **MD/RN/PA/Tech**

Signature: _____

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