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: _____

PREMENOPAUSAL: _____ PERIMENOPAUSAL: _____ POSTMENOPAUSAL: _____

If Postmenopausal: Number of Years: _____ Natural: _____ Surgical: _____

How many pregnancies have you had? _____ How many deliveries have you had? _____

MENSTRUAL HISTORY:

When was your last menstrual period? *(Please specify 1st day of the cycle)* _____

What is your age of onset of menstruation? _____

Are your cycles regular or irregular? _____

Which best describes your menstrual period?

☐ Heavy (7 days or more) ☐ Moderate (3-7 days) ☐ Mild (<2days) ☐ Painful

GYNECOLOGIC HISTORY:

What is your gynecologic history?

☐ Adenomyosis ☐ Endometrial polyps ☐ Leiomyomas (Fibroids)
☐ Chronic Pelvic Pain ☐ Endometriosis ☐ Ovarian Cysts
☐ Ectopic Pregnancy ☐ Infertility ☐ Pelvic Inflammatory Disease
☐ Other (please explain): _____
☐ None

HISTORY of CANCER:

Please specify your personal and family history of cancer:

Personal (Type):_____

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

SURGICAL HISTORY:

Have you had any of the below surgeries?

☐ Cesarean Section ☐ Hysterectomy ☐ Other: _____
☐ D &C ☐ Removal of ovarian cyst ☐ None
☐ Myomectomy ☐ Removal of ovary/ovaries

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MEDICATIONS:

Are you taking any of the below medications?

☐ Depo-Provera ☐ Premarin ☐ Ovarian Stimulation Medications

☐ Lupron ☐ Tamoxifen ☐ Hormone Replacement Therapy

☐ None of the Above ☐ Other: _____

Are you on any form of contraceptive?

☐ Oral Contraceptive ☐ Implant

☐ Intrauterine device (IUD) ☐ Other: _____

☐ None of the above

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.

☐ I acknowledge that I may have a medical chaperone during your exam in accordance with the medical chaperone policy.

Questionnaire Completed By:

Print Name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** ___/___/_____ **Time:** _____ AM/PM

The Patient's 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