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)

BIOPSY QUESTIONNAIRE

Print Name: _____ Date: _____

Age: _____ Weight: _____ Phone Number: _____

Procedure Scheduled: _____

Date of Procedure: _____

Referring Physician: _____

1. Is there any possibility that you are pregnant? ☐ **Yes** ☐ **No**

2. Are you on a fertility protocol? ☐ **Yes** ☐ **No**

3. When was your last menstrual period? _____

4. Are you taking any of the below medications?

☐ Aspirin ☐ Coumadin ☐ Ibuprofen ☐ Other anticoagulants ☐ None

If "Other anticoagulants", please specify: _____

5. Are you planning on taking a sedative or anti-anxiety medication prior to your biopsy appointment?

☐ **Yes** ☐ **No**

6. Do you have any blood clotting disorders? ☐ **Yes** ☐ **No**

If yes, please specify: _____

7. Do you have a history of Myocardial Infarction (MI), angina, or arrhythmia? ☐ **Yes** ☐ **No**

8. Do you have any allergies to any of the below:

☐ Adhesive tape ☐ Latex Gloves ☐ Lidocaine ☐ Nickel ☐ Gadolinium (MRI Contrast)

9. Do you have any physical conditions which would present a difficulty to you for this procedure?

☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

10. Are there additional precautions you would like to add? _____

_____