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)

MRI: GYNECOLOGIC QUESTIONNAIRE

NAME:_____ AGE: _____ DATE: _____

Are you: ☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal

If postmenopausal, please indicate the number of years: _____

Was it natural or surgical? _____

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

What is your age of onset of menstruation? _____

Which best describes your menstrual period?

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

What is your gynecologic history?

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

Please specify your personal and family history of cancer:

Personal (Type):_____

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

Have you had any of the below surgeries?

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

If **Hysterectomy**, please specify if was total or supracervical: _____

Are you taking any of the below medications?

☐ Oral Contraceptives ☐ Premarin ☐ Hormone Replacement Therapy
☐ Depo-Provera ☐ Tamoxifen ☐ Lupron
☐ Ovarian Stimulation Medications ☐ None of above

Reviewed: February 2025