Weinstein Imaging ASSOCIATES

Pelvic / Obstetric Questionnaire

Today's date _____ / _____ / _____ **Birth date** _____ / _____ / _____
month day year

Name _____ Age _____

Referring MD _____ 2nd MD to get report _____

Reason your MD ordered this exam _____

First day of your last menstrual period ____ / ____ / _____ **OR** Postmenopausal (What year?) _____ Had hysterectomy (What year?) _____

Number of previous: Pregnancies _____ Term deliveries _____ Premature deliveries _____
C-sections _____ Miscarriages _____

If you had a recent pelvic or obstetrical ultrasound:
When? _____ / _____ / _____ Where? _____

Do you have a latex allergy? YES NO

FOR PREGNANT WOMEN

Date of first positive pregnancy test:
_____ / _____ / _____ Urine ___ Blood ___
Regular cycles? YES NO
Days between cycles _____
Due date _____ / _____ / _____
Previous birth weights:
Highest ___ lb ____ oz Lowest ___ lb ____oz
Do you have:

_____ Spotting/bleeding
_____ Pain/cramping
_____ Diabetes
_____ High blood pressure
_____ Prior tubal/ectopic pregnancy
_____ Personal or family history of birth defect
What type? _____

Do you smoke? YES NO
Have you had genetic testing? YES NO
Any other pertinent information: _____

_____

_____

FOR ALL OTHERS

Do you currently take:

_____ Tamoxifen / Arimidex / Femara etc.
_____ Hormone replacement
_____ Oral contraceptives
_____ Other pertinent medications:
_____

History of:

_____ Abnormal bleeding
_____ Heavy bleeding
_____ Endometrial ablation
_____ Endometrial biopsy
_____ Endometriosis
_____ Fibroids
_____ Current IUD
_____ Tubal ligation
_____ Personal or family history of breast or ovarian cancer
_____ Pelvic surgery: What type?
_____
_____ Pelvic cancer: What type?
_____