



Pelvic / Obstetric Questionnaire

Today's date ____ / ____ / ____

Birth date: ____ / ____ / ____
month day year last 4 digits of SS#

Name _____ Age _____

Referring MD _____ 2nd MD to get report _____

Why has 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

IF YOU ARE HAVING A **PELVIC** SONOGRAM, ANSWER THESE QUESTIONS:

Do you currently take Tamoxifen / Arimidex / Femara etc. YES NO
Hormone replacement YES NO
Oral contraceptives YES NO
Other pertinent medications _____

Do you have a history of (check all that apply) Abnormal bleeding ____ Endometriosis ____
Heavy bleeding ____ Fibroids ____
Endometrial ablation ____ Current IUD ____
Endometrial biopsy ____ Tubal ligation ____
Pelvic surgery ____ (What type? _____)
Pelvic cancer ____ (What type? _____)

Do you have a family history of breast or ovarian cancer? YES NO

IF YOU ARE HAVING AN **OBSTETRICAL** SONOGRAM, ANSWER THESE QUESTIONS:

Date of first positive pregnancy test ____ / ____ / ____ Urine ____ Blood ____
Regular cycles? YES NO Days between cycles ____ Due date ____ / ____ / ____

Do you have Spotting/bleeding ____ Pain/cramping ____
Diabetes ____ High blood pressure ____
Personal or family history of birth defects ____ What type? _____

Do you smoke? YES NO

ANY OTHER PERTINENT INFORMATION _____