



FEMALE PELVIS QUESTIONNAIRE

RADIOLOGY

NAME: _____ AGE: _____

DIAGNOSIS (Why are you having this study?): _____

PLEASE CHECK EACH BOX THAT APPLIES TO YOU (AND ANSWER QUESTIONS):

Are you having regular menstrual periods? Yes No
 Are you having abnormal menstrual periods? Yes No
 If yes, please describe _____
 When was the first day of your last menstrual period? _____

Are you taking oral contraceptives? Yes No
 Are you taking hormone replacement therapy? Yes No
 Are you taking Tamoxifen? Yes No

Pregnancies
 If yes, how many? _____ How many deliveries? _____

Have you had a Cesarean section (C-section)? Yes No

Fibroids
 Have you received any treatment? Yes No
 Please describe: _____

Pelvic masses or tumors
 If yes, what type? _____
 Have you received any treatment? Yes No
 Please describe: _____

Other pelvic conditions
 If yes, please describe? _____

History of cancer (what type?) _____

Other medical conditions? _____

PRIOR STUDIES AND INTERVENTION:

- Prior MRI (when?) _____ (where?) _____
- Ultrasound (when?) _____ (where?) _____
- CT (CAT) scan (when?) _____ (where?) _____
- Biopsy (when?) _____ (results?) _____
- Hysterosalpingogram (when?) _____ (results?) _____
- Laparoscopy (when?) _____ (results?) _____
- Surgery (type?) _____ (when?) _____
- Other studies and interventions? _____