UNIVERSITY RADIOLOGY

FEMALE PELVIS QUESTIONNAIRE

Name: ______________________ DOB: __________ Today's Date: __________

1. Please describe your symptoms: ______________________

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2. Do you have or have you had, any of the following:

Pelvic Pain	☐ Yes	☐ No
Missed / Irregular Menstrual Cycles	☐ Yes	☐ No
Very Painful Periods	☐ Yes	☐ No
Infertility	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No
Radiation Therapy in the Pelvis	☐ Yes	☐ No
Fibroid	☐ Yes	☐ No
Endometrial Cancer	☐ Yes	☐ No

3. Do you have a history of any of the following:

Endometrial Cancer	☐ Yes	☐ No
Cervical Cancer	☐ Yes	☐ No
Ovarian Cancer	☐ Yes	☐ No

4. Have you had surgery of:

Right Ovary	☐ Yes	☐ No
Left Ovary	☐ Yes	☐ No
Uterus (Including a Caesarian Section or Hysterectomy)	☐ Yes	☐ No
Cervix	☐ Yes	☐ No
Fallopian Tube	☐ Yes	☐ No
Elsewhere in Your Pelvis	☐ Yes	☐ No
Endometrial Sampling or Hysteroscopy	☐ Yes	☐ No

5. Have you ever had:

Uterine Artery Embolization	☐ Yes	☐ No

List operations and approximate dates:

Procedure: ______________________ Date: __________

Procedure: ______________________ Date: __________

6. Are you on Hormone Replacement Therapy: ☐ Yes ☐ No

7. Do you have an IUD: ☐ Yes ☐ No

8. Have you had any of the following exams:

			IF YES, WHEN AND WHERE:
Ultrasound	☐ Yes	☐ No	__________
Hysterosalpingogram or sonohysterogram	☐ Yes	☐ No	__________
Cat Scan	☐ Yes	☐ No	__________
MRI	☐ Yes	☐ No	__________