

ULTRASOUND ASSOCIATES
Women's Imaging Center

GYNECOLOGICAL HISTORY FORM

DATE _____

FIRST NAME _____ LAST NAME _____

AGE _____

DATE OF LAST PERIOD _____ ARE THEY REGULAR? Y OR N

ARE YOU ON **HORMONES** OR **BIRTH CONTROL PILLS**? Y OR N

REASON YOUR DOCTOR ORDERED THIS EXAM TODAY: _____

WHAT ARE YOUR SYMPTOMS? _____

DO YOU CURRENTLY HAVE/OR BEEN DIAGNOSED WITH ANY TYPE OF CANCER? Y OR N

IF YES, WHICH TYPE? _____

ANY FAMILY HISTORY OF CANCER? Y OR N WHICH TYPE? _____

HAVE YOU HAD ANY PELVIC SURGERIES? _____

CIRCLE ALL THAT APPLY:

HX ABNORMAL PAP SMEAR

BLOATING

OVARIAN CYST

IRREGULAR BLEEDING

HEAVY/PAINFUL/ABNORMAL MENSES

ENDOMETRIOSIS

PELVIC PAIN (SPECIFY WHERE) _____

PAINFUL INTERCOURSE

URINARY FREQUENCY