Print Form

# UF Southside Women's Health Specialists

Gynecology Ultrasound Questionnaire

Today's Date:

Date of Birth: Age: Height: Weight:

Home Phone#: Cell#: Work #:

Referring Physician:

Please explain the reason for this visit/reason your referring Provider ordered this test:

Do you still have menstrual cycles? Yes ☐ No ☐ If yes, are they: regular ☐ irregular ☐

Menopausal: Yes ☐ No ☐ If no, when was the 1st day of your last menstrual cycle:

Are you currently taking any hormones or birth control: Yes ☐ No ☐

If yes, what kind: Date started taking birth control:

Have you ever had any female (GYN) surgery including any pelvic surgery (i.e. tubal ligation, hysterectomy, ovary removal, cesarean delivery, ablation, D&C, laparoscopy):

Yes ☐ No ☐ Other ☐

If Other, please specify type and dates:

Family or Personal history of Cancer: (ovarian/Uterine/Breast/Prostate/Colon): please list/dates-

Total # of pregnancies: # of live births:

# of vaginal births: # of Cesarean deliveries:

Have you had a previous pelvic (transvaginal) ultrasound/Songogram: Yes ☐ No ☐

If so, when/where:

What were the results/findings:

*Patient's Signature*:_____