Trinitas Diagnostic Imaging
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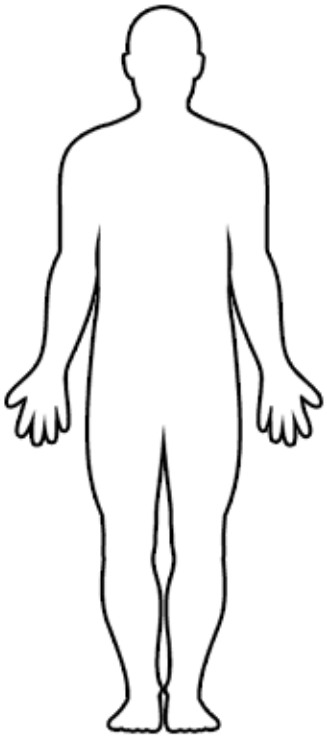
Pelvis Questionnaire - Female

If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.



Please circle the portion of your body that is in pain.

FIRST NAME

LAST NAME

AGE WEIGHT DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?

WHICH AREA IS AFFECTED? ☐ LEFT ☐ CENTRAL ☐ RIGHT

ANY HISTORY OF CANCER? ☐ YES ☐ NO

IF YES, WHERE?

HOW LONG HAVE YOU HAD THIS PROBLEM?

ANY SURGERY OF THE PELVIS? ☐ YES ☐ NO

IF YES, WHEN AND WHAT WAS DONE?

ANY HISTORY OF HYSTERECTOMY? YES NO

☐ ☐

IF YES, WERE OVARIES REMOVED? ☐ YES ☐ NO

ARE YOU RECEIVING HORMONAL THERAPY ? ☐ YES ☐ NO

LAST NORMAL MENSTRUAL CYCLE DATE

POST MENOPAUSAL CYCLE DATE

ANY OTHER MEDICAL CONDITIONS? ☐ YES ☐ NO

DESCRIBE YOUR GENERAL HEALTH?