Inland Empire Imaging Center
260 E Ontario Ave Ste 101 Corona, CA 92879
Tel: 951-284-1920 Fax: 951-284-1921

Patient Questionnaire- Pelvic

1. Name: _____ Date: ___/___/___
2. Date of Birth: ___/___/___ Height: _____ Weight: _____
3. Are you currently taking any medication? ( ) Yes ( ) No
   If so, what type of medication? _____
_____
_____
_____
4. Do you have pelvic pain? ( ) Yes ( ) No ( ) Right side ( ) Left side ( ) Both sides
   If so, how long have you had this pain? _____
5. Have you ever had ovarian cysts? ( ) Yes ( ) No
6. Are you sexually active? ( ) Yes ( ) No
7. Are you pregnant? ( ) Yes ( ) No
8. How many times have you been pregnant? _____
   How many births given? _____
   How many miscarriages? _____
   How many abortions? _____
9. When was the first day of your last menstrual period? _____
10. Is your menstrual cycle normal? ( ) Yes ( ) No
11. Have you had previous pelvic surgery? ( ) Yes ( ) No If so, when? ___/___/___
12. Have you had an ultrasound done before? ( ) Yes ( ) No
    If so, when and where? _____
13. Is there anything you need to disclose to the sonographer before the procedure?

_____
_____

Patient Signature: _____ Date:____/____/____