

SONOHYSTEROGRAPHY STUDY QUESTIONNAIRE

Patient Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____

- Are you post-menopausal? YES NO Are you on Hormone Replacement (HRT)? YES NO
(If you answered YES to question #1 go to question #4)
- What day of your menstrual cycle is today? (The first day of bleeding is day one)
Day: _____
- Are your cycles regular? YES NO
If not, how often do you get your period?: _____
- Do you have episodes of abnormal vaginal bleeding? YES NO
(eg. bleeding which is unusual in amount or timing, after intercourse, before your period, in the middle of your cycle) **If so, please describe:** _____
- Have you ever had:

	Sonohysterography ("sono")	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fibroids <input type="checkbox"/> YES <input type="checkbox"/> NO	Hysteroscopy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Endometriosis <input type="checkbox"/> YES <input type="checkbox"/> NO	Laparoscopy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Uterine Polyps <input type="checkbox"/> YES <input type="checkbox"/> NO	D & C	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Endometrial biopsy (in the past year) <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes: Normal _____ Benign _____?		
A Dye test (to check your fallopian tubes) <input type="checkbox"/> YES <input type="checkbox"/> NO			
Surgery on your uterus, tubes or ovaries <input type="checkbox"/> YES <input type="checkbox"/> NO			
- Pregnancy History
 Years of infertility _____
 Number of pregnancies: _____ Number of Children: _____ C-section YES NO
 Number of miscarriages: _____ In which trimester? 1st 2nd 3rd
 Number of ectopic pregnancies: _____ Number of therapeutic abortions: _____
- Are you **currently trying to conceive** or **planning pregnancy in the future**? YES NO
- Have you ever had a **pelvic infection requiring antibiotics (PID)**? YES NO
- Do you have **any medical conditions**? YES NO
If so, please describe: _____
- Do you have allergies to drugs? YES NO Allergy to Latex? YES NO
If so, please describe: _____
- Do you take **any medications**? YES NO Have you recently taken **any antibiotics**? YES NO
If so, please describe: _____
- Do you want a copy of today results to go to another doctor besides the doctor who sent you today?
(family doctor, specialist) **If so, please give name, address and phone number**
