Patient Name: ____________________
Age:______ DOB:____________________
Today's Date:____________________
Evaluating Physician:____________________
Referring MD:____________________
OB/GYN MD:____________________

Uterine Fibroid Embolization Patient Questionnaire

How did you hear about UFE?____________________
What are your goals or expectations of this treatment? ____________________
____

History of Present Illness:

1. Check all symptoms related to fibroids you currently have:

_____Heavy Bleeding _____Bleeding between Periods _____Clotting
_____Constipation _____Urination Frequency _____Back Pain
_____Leg Pain _____Pelvic Pain _____Abdominal Pain
_____Abdominal Bloating _____Abdominal Distention _____Pain during Intercourse

2. How many days long is your typical period? ____________________
3. If you have heavy bleeding, how many pads/tampons do you use in a 24 hour period?__________
4. If you experience constipation, how long has it been a problem? ____________________
5. How many times do you urinate during the day verses? ____________________
6. How long have you experienced symptoms due to fibroids? ____________________

Describe any other fibroid symptoms you have: ____________________

Gynecological History:

1. How many times have you been pregnant? _______ 2. How many children do you have? _________
3. Number of spontaneous abortions ______________ 4. Number of therapeutic abortions __________
5. Do you hope to have more children? ____________ 6. Date of last Pap test: _________ Neg. or Pos.
7. Do you have a history of anemia? ______________ 8. Have you ever had a blood transfusion (Y/N)? _____
9. If transfused, why and when? ________________ 10. Have you ever had an endometrial biopsy? ________
11. Any history of endometrial biopsy, when did you have it and what were the results? ______________
12. Have you had hormone treatment for fibroids? __________ Date of last treatment? ________________
13. If yes which ones? ______Birth Control _____Depo-Provera _____Estrogen/Progestin ______Lupron
14. Do you have vaginal discharge other than bleeding? __________ Does it have an odor? ____________
15. Any history of pelvic infection (PID or STD)? ___________ If yes, when? ________________________
16. Have you ever had fibroids surgically removed? ____________________
17. Please list any other surgeries involving the uterus and ovaries you have had:____________________
17. Check any symptoms you may have related to menopause:

_________Hot flashes _________Cold hands/feet ________Night sweats _________Headaches
_________Dizziness _________Weight gain ________Fatigue ________ Irritability
________Nervousness _________Insomnia ________Difficulty concentrating

18. List any sexual concerns that may be related to fibroids: ____________________

Past Medical History: *(Check all current or previous medical conditions that apply)*

[ ]Asthma [ ]Depression [ ]High Cholesterol [ ]Mental Illness
[ ]Bleeding Problems [ ]Diabetes [ ]HIV [ ]Seizures
[ ]Blood Clots [ ]Heart Disease [ ]Kidney Disease [ ]Stroke
[ ]Cancer [ ]Hepatitis [ ]Liver Disease [ ]Ulcer
[ ]COPD [ ]High Blood Pressure [ ]Lung Disease
[ ]Other conditions____________________
____

Past Surgical History: *(Please list any previous surgical procedures, and the date of surgery)*

[ ]Tonsillectomy [ ]Arthroscopy
[ ]Spine [ ]Gallbladder
[ ]Appendectomy [ ]Hernia Repair
[ ]Other____

Medications: (Please list all medications you are currently taking including over the counter)

NAME OF MEDICATION DOSE HOW OFTEN TAKEN

1.____
2.____
3.____
4.____
5.____

Allergies:

1. List medicine allergies and reactions: ____
2. Have you ever had "x-ray dye" or Intravenous contrast? ____________If so, explain_______________________
3. Do you tolerate Advil or Motrin? _______ Can you take relaxation medication (Valium/Morphine)? _________
4. Any trouble with Sedation/Anesthesia in the past with you or any of your family members? Please list

Family History:

Family Member	Alive	Deceased	Age	Current/Past Medical Conditions
Mother	[ ]	[ ]	___	______________________________
Father	[ ]	[ ]	___	______________________________
Sister/Brother	[ ]	[ ]	___	______________________________
Sister/Brother	[ ]	[ ]	___	______________________________
Sister/Brother	[ ]	[ ]	___	______________________________
Sister/Brother	[ ]	[ ]	___	______________________________
Children	[ ]	[ ]	___	______________________________

Social History:

Occupation__________________________ Currently Working? [ ]Yes [ ]No
Highest level of education completed: [ ]Grammar[ ]High School [ ]College [ ]Post Graduate
Are you on? [ ]Social Security [ ]Disability [ ]Workers compensation
Marital Status: [ ]Single [ ]Married [ ]Widowed [ ]Separated [ ]Divorced
Tobacco use: [ ]Yes, I've used_____packs/per day for _____years.
[ ]No, I quit _____years ago, I used _____packs/per day for _____years.
[ ]No, I have never used tobacco.
Alcohol use: [ ]Yes, [ ]Daily________ [ ]1 or more times per week [ ]1 or more times per month
[ ]No, I quit _____years ago, I used to drink_____drinks per week.
[ ]No, I don't drink alcoholic beverages
Recreational Drugs: [ ]Yes List__________________________________or [ ]No

Review of Systems: (*Please circle any problems or symptom you have had or currently have)*

General: Recent illness, fever, chills, night sweats, weight loss/gain.
Skin: Bruising/bleeding disorders, rashes, itching, skin cancer, other disease of the skin _____________.
Cardiovascular: Shortness of breath, palpitations, chest pain, swelling in extremities, murmur, angina.
Respiratory: Chronic cough, wheezing, pain with breathing, productive cough.
Gastrointestinal: Nausea, vomiting, diarrhea, constipation, heartburn, ulcers, blood in stool, jaundice.
Genitourinary: Blood in urine, difficulty controlling bowel/bladder, urinary frequency/urgency or burning.
Neurological: Headaches, seizures, tremors, paralysis, loss of consciousness, dizziness.
Musculoskeletal: Joint pain, tingling, burning, backache, neck ache, fatigue.
Psychological: Anxiety, suicidal thoughts, mood swings, constant crying, loss of sleep.

Pt Signature: ____ Date___________________

Pt Name: ____ Date: ___________________

*******************Section below to be filled out by physicians office only.*************************

Physical Exam: V/S: Temp______ Resp______ Pulse_____ B/P (R/L)_____ SAO2%_____ Wt:_____lb

Neuro: AAOX3, pleasant answers questions appropriately, good historian
Resp: Lungs CTA=Bil, no distress
CV: RRR –M/G/R, -JVD/Bruits, - Edema
Abd: BS+X4, - Bruits
Uterus Size __________(8wks size of orange, 12wks up to symphysis pubis, 16 wks between symphysis pubis and umbilicus, 20 wks level navel cantaloupe size)
Position__________
Mobility__________(Freely moveable)
Tenderness_________
Surface_________(Smooth/Firm-Normal)
Shape_________(Pear shaped-Normal)
*For vaginal/pelvic exam please refer to OB/GYN/PCP notes
Musculoskeletal: Full ROM no deficits equal strength throughout
Skin: Intact no open wounds/bruising

Imaging:
Pap: ________________________ Date_________________
Endometrial Biopsy___________ Date_________________
Pelvic Ultrasound_____________ Date_________________
Abd/Pelvic MRI______________ Date_________________

Assessment/Findings: ____

____

____

____

____

____

Plan: ____

____

____

Pharmacy Used/ Location: ____