

CURRENT DATE:  
 PATIENT NAME:  
 PATIENT NUMBER:  
 PATIENT DOB:

**Uterine Fibroid Embolization**

Patient Information

**Confidential Record: Information contained here will not be released except when you have authorized us to do so.**

**OB/GYN History:**

What symptoms are you experiencing due to the presence of fibroids?  
 (circle the response that most closely reflects the severity of your symptoms)

	Not at all	Very Mild	Moderate	Severe	Duration
Abnormal bleeding	0	1 2	3 4	5	____Months
Menstrual cramping	0	1 2	3 4	5	____Months
Pelvic pain	0	1 2	3 4	5	____Months
Frequent urination	0	1 2	3 4	5	____Months
Abdominal bloating	0	1 2	3 4	5	____Months
Pain during intercourse	0	1 2	3 4	5	____Months
Other (please describe) _____					

Which item above describes your most significant symptom? \_\_\_\_\_

**Menstrual History:**

	Yes	No
Are you post menopausal?		
Are your periods regular?		
<ul style="list-style-type: none"> <li>• What was the first day of your last period? _____</li> <li>• Number of days in your cycle? _____</li> <li>• How many pads or tampons do you use on your heaviest days? _____</li> </ul>		
Do you bleed between periods?		
Do you pass clots?		
Could you be pregnant?		
Has your blood count been low? <ul style="list-style-type: none"> <li>• If so what treatments did you receive?              _____              _____</li> </ul>		

**Birth Control History:**

Are you heterosexually active \_\_\_\_yes \_\_\_\_no

Indicate birth control methods you use  
 \_\_\_\_None                      \_\_\_\_Condoms  
 \_\_\_\_Diaphragm              \_\_\_\_Ovaries Removed  
 \_\_\_\_IUD                        \_\_\_\_Tubal ligation  
 \_\_\_\_Partner had vasectomy  
 \_\_\_\_Oral contraceptives (the pill)

If you were on the pill, how long have you been off of it? \_\_\_\_\_

**Pregnancy History:**

# of pregnancies \_\_\_\_ # of live births \_\_\_\_  
 # of miscarriages \_\_\_\_ # of C-section \_\_\_\_  
 # of tubal (ectopic) pregnancies \_\_\_\_  
 # of induced abortions \_\_\_\_  
 Do you plan on having more children? \_\_\_\_yes \_\_\_\_no

**Fertility History:**

Do you consider yourself infertile?  
 \_\_\_\_yes              \_\_\_\_no

If yes, have you tried or had any of the following?  
 \_\_\_\_Previous treatment for infertility  
 \_\_\_\_Unprotected sex for 1 year without pregnancy  
 \_\_\_\_3 or more consecutive miscarriages

**GYN Disorders:**

Please indicate if you have had the following:  
 \_\_\_\_Adenomyosis  
 \_\_\_\_Endometriosis  
 \_\_\_\_Pelvic Adhesions  
 \_\_\_\_Pelvic Inflammatory Disease

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**Previous Diagnostic Test and Surgeries:**

Please indicate if you have had any of the following:

<input type="checkbox"/> Ultrasound	date performed: _____
<input type="checkbox"/> CTscan	date performed: _____
<input type="checkbox"/> MRI	date performed: _____
<input type="checkbox"/> Pap smear	date performed: _____
<input type="checkbox"/> Endometrial biopsy	date performed: _____

**Prior Treatment of current symptoms**

Please indicate if you have had any of the following:

Lupon (within the last 3 months? \_\_\_\_\_)  
(how many injections \_\_\_\_\_)

Oral contraceptive (within the last 3 months? \_\_\_\_\_)

Depo-provera (within the last 3 months? \_\_\_\_\_)

NSAIDS (within the last 3 months? \_\_\_\_\_)

Other (Provera, Aygeatin, Magase, Synarel) (within the last 3 months? \_\_\_\_\_)

**Gyn Surgical History**

<input type="checkbox"/> D & C	date performed: _____
<input type="checkbox"/> Endometrial ablation	date performed: _____
<input type="checkbox"/> Myomectomy	date performed: _____
<input type="checkbox"/> Myolysis	date performed: _____
<input type="checkbox"/> Oophorectomy	date performed: _____
<input type="checkbox"/> Ovarian cystectomy	date performed: _____

