Thank you for taking the time to answer these important questions. Our goal is to learn more about you, so that we may give you detailed information about all your options for treating your uterine fibroids.

What would you say is the ***most bothersome*** fibroid-related problem that brings you here today?

❑ Heavy menstrual bleeding ❑ Bulk symptoms such as frequent urination ❑ Pelvic pain

❑ Infertility ❑ Other Please describe: _____

_____

Menstrual and Fibroid History

When were you first diagnosed with fibroids? _____ (Approx. Month and Year)

How were you first diagnosed with fibroids? _____

_____

When did they begin to cause problems? _____ (Approx. Month and Year)

Age periods began: _____

Are you in menopause? ❑ No ❑ Yes: Any bleeding since menopause? ❑ No ❑ Yes

Do you have frequent urination? ❑ No ❑ Yes: When did this start? _____

How often do you urinate during the day? Every _____ hours

Do you leak urine? ❑ No ❑ Yes: ❑ With Urgency ❑ With Activity ❑ Both

Do you get up at night to urinate? ❑ No ❑ Yes: Number of times? _____

Do you have any problem with constipation? ❑ No ❑ Yes: When did this start? _____

Do you have: ❑ Bloating ❑ Pelvic pressure ❑ Back pain ❑ Other: _____

***If you're in menopause, please skip to Gynecologic History.

Date of your last normal menstrual period (first day): _____

Are your periods: ❑ Regular ❑ Irregular

Length of periods (days): _____ Number of heavy days: _____

Number of days between periods: _____

On those heavy days, did you wear: ❑ Pads ❑ Tampons ❑ Both ❑ Other: _____

How often did you have to change your pad/tampon? Every _____ hours

Do you pass clots? ❑ No ❑ Yes: How big? _____

Ever soak through your clothes? ❑ No ❑ Yes

Any history of anemia? ❑ No ❑ Unsure ❑ Yes: What was your last Hemoglobin? _____

Date of last Hemoglobin? _____

Have you ever needed a blood transfusion? ❑ No ❑ Yes: Please describe _____

_____

Any bleeding between periods? ❑ No ❑ Yes: Please describe _____

_____

During your periods, do you feel: ❑ Dizzy ❑ Lightheaded ❑ Fatigue ❑ Other: _____

_____

Are your periods painful? ❑ No ❑ Yes: how many days? _____

Any pain between periods? ❑ No ❑ Yes: Please describe _____

_____

Gynecologic History

Number of pregnancies _____ Number of abortions _____ Number of miscarriages _____

Number of ectopic (tubal) pregnancies _____ Number of C-sections _____

Number of living children _____ Ages of living children_____

Number of pre-term deliveries (less than 37 weeks) _____

Have you ever had an abnormal pap smear? ❑ No ❑ Yes: Please specify results: _____

_____

If yes, did you require treatment of your cervix? ❑ No ❑ Yes: ❑ LEEP ❑ Cone ❑ Cryotherapy

❑ Other: _____

Are you sexually active? ❑ No ❑ Yes: ❑ Men ❑ Women ❑ Both

Have you ever had a sexually transmitted infection? ❑ No ❑ Yes: Please specify: _____

_____

Do you have pain with intercourse? ❑ No ❑ Yes: ❑ With insertion ❑ With deeper penetration

❑ Both

Are you using a method of birth control? ❑ No ❑ Yes: Please specify: _____

Do you desire future fertility? ❑ No ❑ Yes: In the near future? _____

If you do not desire future fertility, would you consider a hysterectomy? ❑ Yes ❑ No: Why not?

_____

Social History

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

❑ Living with Partner

School Completed: ❑ High School ❑ College ❑ Graduate School ❑ Other: _____

Current or most recent job: _____

Travel outside of the U.S. in the last 6 months? _____

Ever smoked? ❑ No ❑ Yes: How many packs per day? _____ How many years? _____

Quit date: _____

Do you drink alcohol? ❑ No ❑ Yes: What type? _____

How many drinks per week? _____

Do you currently use any recreational drugs (like marijuana, cocaine, heroin, methamphetamines)?

❑ No ❑ Yes: Please list: _____ How often? _____

Have you ever been sexually abused, threatened or hurt by anyone? ❑ No ❑ Yes:

If you feel comfortable, please describe: _____

_____

Current Medications (including vitamins, herbs and supplements)

Drug Name	Dose	Who prescribed it to you?

Allergies to Food or Drugs (Describe Reaction): ❑ No ❑ Yes:

_____

_____

_____

Have you ever had a reaction to x-ray contrast? ❑ No ❑ Yes: Please specify: _____

_____

Past Medical and Family History

Please mark all that applies to you and add comments as needed.

Illness	Self	Age of onset	Family Maternal/Paternal	Patient Comments	Physician Notes
Diabetes					
Stroke					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Osteoporosis					
Hepatitis					
HIV/AIDS					
Tuberculosis					
Birth Defects					
Drinking or Drug Problems					
Cancer (what type?)					
Mental illness or Depression					
Alzheimer's Disease					
Other					

Please list your previous hospitalizations, surgeries and serious illness and their approximate dates:

Year	Operation or condition treated

Review of Systems

Please check all that applies to you and add comment as needed.

	Yes	No	Patient Comments	Physician Comments
Have had any recent weight loss/ gain, fatigue, fever or chills?				
EYES (blurry vision, double vision, dry eyes, discharges)				
EAR, NOSE, THROAT (discharges, irritations, bleeding)				
CARDIOVASCULAR (stroke, high blood pressure, on blood thinners)				
RESPIRATORY (allergies, asthma, emphysema, sleep apnea)				
GASTROINTESTINAL (ulcers, hepatitis, constipation, pancreatitis, IBS)				

	Yes	No	Patient Comments	Physician Comments
GENITOURINARY (incontinence, recurrent UTIs, stones, sexual problems)				
MUSCULOSKELETAL (arthritis, fractures, joint replacement)				
SKIN (rashes, non-healing wound)				
BREASTS (lumps, nipple discharge, dimpling)				
NEUROLOGIC (numbness, tingling, MS, problems on balance)				
PSYCHIATRIC (depressions, mood changes)				
ENDOCRINE (hormones/ metabolism/thyroid)				
HEMATOLOGIC/LYMPHATIC (blood or bleeding problems, swollen lymph nodes or “glands”)				
IMMUNOLOGIC (HIV, immunocompromised)				

You were referred by: _____

Would you like us to send him or her a letter? ❑ No ❑ Yes: Please provide:

Address: _____

_____

Phone number: _____

SIGNATURES REQUIRED ON NEXT PAGE

Patient Signature

DATE | TIME | SIGNATURE (Patient /Legal Designated Representative)

PRINT NAME | RELATIONSHIP TO PATIENT

Interpreter

If an interpreter participated in this discussion:

PRINT SHC in-person interpreter name | Video or TEL Interpreter ID# | Language

Physician Signature:

DATE | TIME | PHYSICIAN SIGNATURE | PRINT NAME