FIBROID MEDICAL HISTORY QUESTIONNAIRE

Full Name: ____
(Last) (First) (Middle Name)

Address:
____

City: ________________________ State: ____________ Zip Code: ______________

Country: _________________ SSN: ____________ Age: ____ Date of Birth: ___________

Work/Cell Telephone: ______________________ Home Telephone: ___________________

E-mail address: ____

Occupation: _________________________

Single ___ Married ___ Divorced ___ Other ___

Race: ______________________________

How did you hear about us? ____

Date of your last physical exam: ___________ Present Weight/Height ________________

Physician Name: ________________________ Telephone: ___________________________
(Internal Med or Primary Care)

Physician Address: ____
(Internal Med or Primary Care)

Physician Name: _______________________ Telephone: _______________________________
(OB/GYN)

Physician Address: ____
(OB/GYN)

FOR OFFICE USE ONLY:

_____ PREDET CLEARED: Y N DATE ____/_____/_____ REASON: _________________________

_____ FINANCE OFFICE: Y N DATE _____/_____/_____

_____ RECORDS REC'D: MEDICAL HISTORY: Y N DATE _____/_____/_____

ULTRASOUND REPORT: Y N DATE _____/_____/_____

_____ MD APPOINTMENT: Y N DATE _____/_____/_____ SCHEDULED FOR: _____/_____/_____

_____ MRI APPOINTMENT: Y N DATE _____/_____/_____ SCHEDULED FOR: _____/_____/_____

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Please answer the following questions as accurately as possible. Place a ✓ mark in the appropriate column.

Pre-Determination				
	YES	**NO**	**Unsure**	**Comments/ Details**
Have you been diagnosed by a medical physician that you have Uterine Fibroids?				
Do you have any scars in the abdominal or stomach area from previous surgery?				
Are you claustrophobic?				
Do you have any metal implants, clips or IUD?				
Do you have any tattoos in the abdominal region? Body piercing? Abdominal liposuction?				
Have you had an abnormal PAP smear in the last year?				
Have you had a previous Uterine Artery Embolization (UAE / UFE)				
Are you currently pregnant or wish to become pregnant?				
When was your last period? If over 6 months, are you considered menopausal?				
What is your most recent height and weight? (MRgFUS requires under 250lbs)				
Have you had a recent ultrasound or MRI? If so, please send a copy of the report before your appointment.				
Have you inquired about this procedure with your insurance company?				

If you answered **yes** to any of the above questions, please explain and provide details, such as dates and descriptions. Where are the abdominal scars located and what the scarring was due to, i.e., C-section or other surgery.

____

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How would you describe your overall health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

MEDICAL HISTORY				
Have you had or do you now have?	**YES**	**NO**	**Unsure**	**Comments**
Heart Disease				
Diabetes				
Pulmonary Disease				
High Blood Pressure				
Stroke/TIA				
Thromboembolism				
Anemia				
Asthma or Emphysema				
Breast Cancer				
Cervical Cancer				
Any history of Cancer				
Renal Disease				
Clotting problems or coagulation disorders				
Previous surgery: please list with dates				

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PELVIC and GYN				
Have you had or do you now have?	**YES**	**NO**	**Describe/Dates**	**Comments**
Heavy bleeding, clotting or spotting between periods and/or vaginal bleeding (Menorrhagia)				
How far apart are your periods				
How many days is your average period				
Vaginal bleeding which has not been diagnosed				
Painful intercourse				
Abdominal or pelvic cramping with periods				
Abdominal or pelvic pain or pressure				
Abnormal PAP results – If so, when and what treatment?				
History of STD's, Endometritis, or Endometriosis				
Number of previous pregnancies				
Number of term deliveries, preterm births, miscarriages, or elective abortions				
Any Ovarian cysts				

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Have you had or do you now have?	YES	NO	Describe/Dates	Comments
Any history of fertility testing or treatment				
Stillbirth/ Miscarriage				
Pelvic Carcinoma or pre-malignant conditions				
Pelvic Inflammatory Disease				
Are you considered peri, pre or post Menopausal				
Are you taking any Hormone therapy medications				

URINARY HISTORY

Have you had or do you now have?	YES	NO	Describe/Dates	Comments
Pain or burning on urination				
Frequent urination, day or night				
Extreme urge to urinate				
Involuntary loss of urine				

GASTROINTESTINAL HISTORY

Bright red blood in stool				
Diarrhea or Constipation				
Nausea/Vomiting				
Change in bowel habits				

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MUSCULOSKELETAL HISTORY				
Back Pain				
Any Muscle Pain				
Leg/Ankle swelling				
SKIN				
Rashes				
Laser Hair Removal Abdominally				
Other				

NEUROLOGICAL/PSYCHIATRIC HISTORY				
Have you had or do you now have?	**YES**	**NO**	**Describe/Dates**	**Comments**
Depression				
Emotional Difficulty or difficulty with thinking or problem solving				
Headaches				
Blackouts or Dizziness				
Any leg(s) Weakness				
Loss of sensation				
Other				

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PLEASE LIST ALL MEDICATIONS YOU TAKE REGULARLY		
Medication Name	**Frequency/dose**	**Comments**
SMOKING: Do you currently smoke or have a history of smoking? __YES __NO If so, how much per day, and for how long (years)?		
ALCOHOL: Do you drink? __YES __NO If so, how often do you drink alcohol? How many drinks per week?		

ALLERGIES (Please list if you have ever had any adverse reactions.)		
Allergic To:	**Adverse Reaction**	**Comments**

FAMILY MEDICAL HISTORY				
Family Member	**Health Status Please Indicate if family member is (was) in Good Health or Poor Health**	**Age**	**If deceased, list cause of death**	**Comments (Important Health issues – Any Cancers, Diabetes, Heart Disease, Blood clots, Genetic Disorders)**
Mother				
Father				
Brother				
Sister				
Children				
Extended				

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family members				

PLEASE READ and COMPLETE NEXT SECTION

This last section <u>must be completed</u> for us to be able to evaluate your symptoms. In the space below, please provide us, in your own words and expressing your feelings, a description of your symptoms related to you menstrual cycle, and any problems you have had related to your fibroids. For example, how many days, irregular bleeding, is there spotting in between cycles, your pain and/or anything else that will help us to better understand how you feel. Please note, this procedure is <u>not</u> recommended for women who desire future pregnancies. Please feel free to use additional paper if necessary.