FIBROID FOCUS

Name _____

Age _____

Date _____

UFE Patient History Questionnaire

How did you hear about Dr Fischer?

When were you first told you have uterine fibroids (month/year)?

How were you diagnosed? *(Please circle one)*

Routine Pelvic Exam
Ultrasound
Both

What symptoms, if any, were you having at the time of the <u>first diagnosis</u>? *(Please circle all that apply)*

None
Heavy menstrual periods
Excessive menstrual cramping and pain
Urinary frequency
Pelvic pain
Pelvic pressure
Constipation
Back pain
Painful sex
Other:

What symptoms, if any, have you had in the past 6 months? *(Please circle all that apply)*

None
Heavy menstrual periods
Excessive menstrual cramping and pain
Urinary frequency
Pelvic pain
Pelvic pressure
Constipation
Back pain
Painful sex
Other:

Have your symptoms been getting worse? Yes or No

What symptom is causing the most problems?

Have you ever been treated for your fibroids? Yes or No

If Yes, please circle all that apply and specify the month/year of treatment.

Surgery: Myomectomy (open)
Laparoscopic surgery
Hysteroscopic surgery

Hormone therapy: Birth control pills
Lupron injections

Other:

Please tell us about your menstrual periods:

Are your menstrual periods regular or irregular?

How often do they occur? *(Please circle one)*

Monthly
Every _____ days
Other: *(explain)*

How long do they last (# days)?

What days are heaviest?

On the heaviest days, how often do you change tampons/pads?

Do you ever pass blood clots?
If so, are they small, medium or large?

Have you ever been diagnosed with anemia (low iron/blood levels)? Yes or No

If Yes, have you ever had a blood transfusion? Yes or No
If Yes, when? _____

Have you had an iron infusion? Yes or No

Have you ever had problems with infertility? Yes or No

If Yes, please explain.

How many times have you been pregnant?

How many children do you have?
Please specify the genders and ages of your children:

Were your children delivered vaginally or by c-section?

Did you have any complications with the pregnancies or deliveries? Yes or No
If Yes, please explain.

Do you plan to have (more) children? Yes or No

Who is your gynecologist?
Please include name, address and phone number, if applicable.

How long have you seen him/her?

When was your last routine gynecological exam (month/year)?

When was your last routine PAP smear (month/year)?

Where was it performed?

Was it normal or abnormal?

Have you ever had an abnormal PAP smear? Yes or No

If Yes, when?

Have you ever had a sexually transmitted disease? Yes or No

If Yes, please specify dates and treatments (if any):

Have you ever had a pelvic Ultrasound? Yes or No

If Yes, when and where was it performed?

Have you ever had a pelvic MRI? Yes or No

If Yes, when and where was it performed?

Are you allergic to Iodine or X-Ray Contrast Dye? Yes or No

Do you have any metallic foreign objects in your body? Yes or No

If Yes, please describe.

Are you claustrophobic (afraid of small, tight places)? Yes or No

Tell us about you:

Are you: married
single
divorced
widowed

Do you work? Yes or No

If Yes, where and what do you do?

Do you smoke or have you ever smoked? Yes or No

If Yes, how often (packs per day) or when did you quit?

Additional information: _____

_____

_____

_____

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