Uterine Fibroid Embolization Patient Questionnaire

How did you hear about UFE?_______________________________________________________________
What are your goals or expectations of this treatment? ____________________________________________
________________________________________________________________________________________

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

- Heavy Bleeding
- Bleeding between Periods
- Constipation
- Urination Frequency
- Leg Pain
- Pelvic 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: _________________________________________________

1. How many times have you been pregnant? _______ 2. How many children do you have? __________

Gynecological History:

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)? ______


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

___________________________________________

Patient Name: _____________________________________
Age: _____ DOB: __________________________________
Today’s Date: _____________________________________
Evaluating Physician: ______________________________
Referring MD: _____________________________________
OB/GYN MD: _____________________________________
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:

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Alive</th>
<th>Deceased</th>
<th>Age</th>
<th>Current/Past Medical Conditions</th>
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<td>Mother</td>
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<td>Children</td>
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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.
[ ] Yes, 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
[ ] Yes, I quit_____ years ago, I used to drink____ drinks per week.
[ ] Yes, 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.
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: _____________________________________________________________________