

UTERINE FIBROID EMBOLIZATION

Patient Information Form

Hospital or Ambulatory Center

Street Address

City, State, Zip

Telephone Number

Fax Number

Referring to Doctor: _____

MR or _____

Married _____

Status of Marital _____

Date of Procedure: _____ Primary: _____ IR: _____

MEDICAL HISTORY:

Has your doctor in the last year told you of the following conditions? (If yes, please specify below)

Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, do you take Coumadin? *	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple myeloma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cholecystitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypertrophic cardiomyopathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Myocardial infarction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Phlebotomy or transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Collagen disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autoimmune disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OB/GYN HISTORY:

Pre-procedure: _____ 3 Months: _____ 12 Months: _____

What symptoms have you experienced since the beginning of Menstrual? *

(Circle the appropriate level of severity: NONE, Mild, Moderate, Severe, Very Severe)

	Not at all	Very mild	Moderate	Very severe	Duration
Menstrual cramping	0	1 2	3 4	5	_____ weeks
Menstrual cramping	0	1 2	3 4	5	_____ weeks
Pelvic pain	0	1 2	3 4	5	_____ weeks
Excessive bleeding	0	1 2	3 4	5	_____ weeks
Pain during intercourse	0	1 2	3 4	5	_____ weeks

Other (Please describe): _____

What are the most difficult aspects of your menstrual cycle? _____

Menstrual History:

Are you postmenopausal? Yes No

What was the first date of your first menstrual cycle? _____

Are periods regular? (7-9 days) Yes No

Menstrual cycle length (days): _____

How many pads or tampons used during the heaviest day of your period? _____

Do you bleed between periods? Yes No

Do you have clots? Yes No

Do you have heavy periods? Yes No

Birth Control History:

Are you currently using birth control? Yes No

If yes, what type of birth control are you using?

- None
- Condoms
- Oral contraceptives (the pill)
- IUD
- Intrauterine
- Injectable / Implantable
- Tubal ligation (Tubal linc)
- Diaphragm (Cervical cap)
- Male condom

If you have ever taken birth control medication, how long have you been off of it? _____

Pregnancy History:

Number of pregnancies _____ Number of live births _____

Number of miscarriages _____ Number of induced abortions _____

Number of tubal (ectopic) pregnancies _____ Number of cesarean sections _____

Are you planning on having children in the future? Yes, likely within the next 2 years.

Would like to have them, require surgery

No

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

IUI or IVF or other assisted reproductive techniques

GYN Disorders:

Have you ever had any of the following gynecologic disorders?

- Endometriosis Yes No
- Pelvic inflammatory disease Yes No
- Pelvic adhesions Yes No
- Adenomyosis Yes No

Other (Specify disorder): _____

Previous Diagnostic Tests:

Have you ever had any of the following diagnostic tests?

- Ultrasound Date performed: _____
- CAT scan Date performed: _____
- MRI Date performed: _____
- HSG Date performed: _____
- Hysteroscopy Date performed: _____

Prior Treatment of Symptoms:

- Lupron injections Within the last 3 months? Yes No
How many injections? _____
- Oral contraceptives Within the last 3 months? Yes No
- Non-steroidal anti-inflammatory drugs (i.e., Advil) Within the last 3 months? Yes No
- Depo-provera Within the last 3 months? Yes No
- Other (Specify drug) Within the last 3 months? Yes No

GYN Surgical History:

Have you had any of the following types or steps of procedures? (Please include dates)

- Myomectomy Date Performed: _____
- Myohysis Date Performed: _____
- D & C Date Performed: _____
- Ovarian cystectomy Date Performed: _____
- Endometrial ablation Date Performed: _____
- Tubal ligation Date Performed: _____
- Cholecystectomy Date Performed: _____

SURGICAL HISTORY:

Please list any other surgery or procedures you have had:

_____ Date Performed: _____

_____ Date Performed: _____

_____ Date Performed: _____

_____ Date Performed: _____

MEDICATIONS:

Please list any medications you are currently taking. (Please include vitamins and any over the counter medications)

ALLERGIES:

Do you have any allergies to medications (pain medications, antibiotics), x-ray dye, heparin, latex, or anything else?

Do you smoke cigarettes? Yes No

HOW DID YOU FIRST HEAR ABOUT THIS PROCEDURE?

- Family Physician Public radio
- Socialist Internet (page only)
- Family friend Television show
- Newspaper/magazine Other

Form Reviewed by _____