PATIENT HEALTH HISTORY FORM
UTERINE FIBROID EMBOLIZATION – NEW PATIENT

TODAY'S DATE: ____ MR # ____________

NAME: ____

DATE OF BIRTH: ____

Who is your OB/GYN Physician? ____

What is your most significant symptom? _____________________________________

When were you diagnosed with fibroids? ____________________________________

OB/GYN HISTORY:

What symptoms are you experiencing due to the presence of fibroids?
(Circle the response that most closely reflects the severity of your symptoms)

	Not At All	**Very Mild**	**Moderate**	**Very Severe**	**Duration**
Abnormal Bleeding	0	1 2	3 4	5	__________
Menstrual Cramping	0	1 2	3 4	5	__________
Pelvic Pain	0	1 2	3 4	5	__________
Frequent Urination	0	1 2	3 4	5	__________
Abdominal Bloating	0	1 2	3 4	5	__________
Pain during Intercourse	0	1 2	3 4	5	__________

MENSTRUAL HISTORY:

Are you postmenopausal? Y N
What was the first date of your last menstrual period? _______________
Are your periods regular? (22-25 days) Y N
Number of days in your cycle ________________________
How many pads or tampons used during the heaviest day of your period? ______
Do you bleed between periods? Y N
Do you pass clots? Y N
Could you be pregnant? Y N

BIRTH CONTROL HISTORY:

Are you heterosexually active? Y N

If yes, what type of birth control do you use?

_____ None	_____ Injectable/Implantable
_____ Condoms	_____ Tubal Ligation (tubes tied)
_____ Oral Contraceptives (pill)	_____ Oopherectomy (ovaries removed)
_____ IUD	_____ Partner Vasectomy
_____ Diaphragm	

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? (answer below)

_____ Yes, likely within the next 2 years

_____ Would like to keep this option open

_____ No

Do you consider yourself infertile? Y N

If yes, have you tried or had any of the following?

_____ Previous treatment for infertility

_____ Unprotected sex for 1 year without pregnancy

_____ 3 or more consecutive miscarriages

GYN DISORDERS:

Please indicate whether you have any of the following gynecological disorders:

Endometriosis	Y	N
Pelvic Inflammatory Disease	Y	N
Pelvic Adhesions	Y	N
Adenomyosis	Y	N

Other (please describe) ____

____

PREVIOUS DIAGNOSTIC TESTS:

Please indicate whether you have had any of the following diagnostic tests:

______ Ultrasound Date Performed: ____________________________

______ CAT Scan Date Performed: ____________________________

______ MRI Date Performed: ____________________________

______ PAP Smear Date Performed: ____________________________

______ Endometrial Biopsy Date Performed: ____________________________

PRIOR TREATMENT OF SYMPTOMS:

______ Lupron Injections Within the last 3 months? Y N

______ How many injections? Last injection (date) ________________________

______ Oral Contraceptives Within the last 3 months? Y N

______ Non-steroidal anti-inflammatory drugs (i.e. Advil)
Within the last 3 months? Y N

______ Depo-Provera Within the last 3 months? Y N

______ Other (Provera, Aygestin, Megase, Synarel)
Within the last 3 months? Y N

GYN SURGICAL HISTORY:

Have you had any of the following gynecological procedures? (Please note dates)

______ Myomectomy Date Performed: ________________________

______ Myolysis Date Performed: ________________________

______ D & C Date Performed: ________________________

______ Ovarian Cysterectomy Date Performed: ________________________

______ Endometrial Ablation Date Performed: ________________________

______ Tubal Ligation Date Performed: ________________________

______ Oophorectomy Date Performed: ________________________

MEDICAL HISTORY:

Who is your Primary Care Physician? ____________________________________

Other than your PCP or OB/GYN other physicians who are treating you?

____

____

Do you have or have you had any of the following conditions? (If yes, please specify below)

Asthma	Y	N	Diabetes	Y	N
Hypertension	Y	N	If yes, do you take Glucophage?	Y	N
Head Injury	Y	N	Stomach Ulcers	Y	N
Seizures	Y	N	Multiple Myeloma	Y	N
Glaucoma	Y	N	Cancer	Y	N
Thyroid Disease	Y	N	Myasthenia Gravis	Y	N
Heart Disease	Y	N	Anemia	Y	N
Lung Disease	Y	N	Bleeding Disorders	Y	N
Liver Disease	Y	N	Pheochromocytoma	Y	N
Kidney Disease	Y	N	Osteoarthritis	Y	N
Intestinal Disease	Y	N	Osteoporosis	Y	N

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, betadine, latex or anything else?

____

FAMILY HISTORY:

Mother	Alive	Deceased	Age _____	Ailments _____________________
Father	Alive	Deceased	Age _____	Ailments _____________________
Sister	Alive	Deceased	Age _____	Ailments _____________________
	Alive	Deceased	Age _____	Ailments _____________________
Brother	Alive	Deceased	Age _____	Ailments _____________________
	Alive	Deceased	Age _____	Ailments _____________________
Children	Alive	Deceased	Age _____	Ailments _____________________
	Alive	Deceased	Age _____	Ailments _____________________

SOCIAL HISTORY:

Occupation: ____

Marital Status: ______ Married ______ Single ______ Widowed ______ Divorced

Do you use Alcohol? Y N

Do you smoke Cigarettes? Y N How much? ___________________

Do you use other substances? Y N ______________________________

Form Reviewed By: ____