VASCULARCARE
Experts with Minimally Invasive Treatments

**New Patient Form: Uterine Fibroids**

**Patient Name**: _____

**Date**: _____/_____/_____ **Date of Birth:** _____/_____/_____

**Directions: Please answer the following questions. Provide estimates for dates of occurrence.**

1. Why are you here today? _____
2. How did you hear about us? _____
3. Name, address and telephone number of your primary care practitioner.

   _____
4. Name, address and telephone number of your OB/GYN provider.

   _____
5. When were you first diagnosed with uterine fibroids (month/year)? _____
6. How were you diagnosed with uterine fibroids? (Circle one)

   Routine Pelvic Exam Ultrasound Both Pelvic Exam and Ultrasound
7. Have you ever had a pelvic ultrasound? Yes No

   If yes, when and where was it performed? _____
8. Have you ever had a pelvic MRI? Yes No

   If yes, when and where was it performed? _____
9. What symptom(s) were you having at <u>initial diagnosis</u> and what symptoms, if any are you having <u>now</u>?

**<u>Please check all that apply</u>**

| Symptom(s) | Initial Diagnosis | Now |
|---|---|---|
| None | | |
| Back pain | | |
| Constipation | | |
| Excessive menstrual cramping and/or pain | | |
| Heavy menstrual periods | | |
| Painful intercourse | | |
| Pelvic pain | | |
| Pelvic pressure | | |
| Urinary frequency | | |
| Other: | | |

10. Which symptom is causing you the most problem or concern? _____
11. How long have you had these symptoms? _____
12. Have your symptoms gotten **better** <u>or</u> **worse** in the past 6 months? _____
13. Overall, how much of an impact do your symptoms have on your personal or work life?

    **(None)** 0 1 2 3 4 5 **(Severe)**

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**OB/GYN HISTORY:**

**14.** Date and results of last PAP smear: _____

**15.** Have you ever had an abnormal PAP smear? Yes No If yes, when? _____

**16.** Number of: Pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

**17.** Number of: Vaginal deliveries: _____ C-Sections: _____

**18.** Did you ever have infertility problems (difficulty getting pregnant)? Yes No

**19.** Did you ever have complications with any of your pregnancies or deliveries? Yes No
If yes, please describe: _____

**20.** Do you wish to have more children? No Yes (if yes, please mention to doctor)

**MENSTRUAL CYCLE HISTORY:**

**21.** Are your menstrual periods: regular irregular

**22.** How often do you have a menstrual period? Monthly every _____ days Other: _____

**23.** How many days does your menstrual period last? _____

**24.** What day(s) is/are the heaviest? _____

**25.** On the heaviest day(s), how often do you change your tampon/pad in a 24 hour period? _____

**26.** Do you ever pass blood clots?: Yes No
If yes, are they: small medium large

**TREATMENT HISTORY:**

**27.** Have you had any of the following treatments for your fibroids?

**Please check all that apply**

| | Treatment | Month/Year |
|---|---|---|
| Surgery: | Myomectomy (open) | |
| | Laparascopic surgery | |
| | Hysteroscopic surgery | |
| Hormone Therapy: | Birth control Pills | |
| | Lupron injections | |
| Other: | | |

**SOCIAL HISTORY:** Current or previous Occupation:

_____

**28.** Tobacco use: ☐
Never ☐ Quit If so, when? _____
☐ Current: ☐ Cigarettes Amount per day: _____ Number of years: _____

**29.** Alcohol: ☐ Never Social ☐ Occasionally ☐ Daily

**30.** Recreational Drug use: ☐ Never ☐ Social ☐ Occasionally ☐ Daily

**SURGICAL HISTORY:** (Please include any major operations you have had)

_____

_____

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**MEDICAL HISTORY:** **Height:** _____feet _____inches **Weight:** _____pounds

Please indicate whether you have a history of any of the following:

**Eyes:** ☐ No problems
☐ Other_____
**Ear/Nose/Throat:** ☐ No problems
☐ Other_____

**Cardiac:** ☐ No problems
☐ High blood pressure
☐ Irregular heart beat
☐ Mitral Valve Prolapse
☐ Other_____

**Endocrine** ☐ No problems
☐ Diabetes
☐ Other_____

**Gastrointestinal:** ☐ No problems
☐ Bleeding
☐ Liver disease
☐ Ulcer
☐ Other_____

**Genitourinary:** ☐ No problems
☐ Kidney disease
☐ Sexually transmitted disease(s)
☐ Chlamydia
☐ Gonorrhea
☐ HPV
☐ Syphilis
☐ Other _____
If yes, when and treatment:
_____

**Hematological/ Lymphatic:** ☐ No problems
☐ Anemia
☐ Blood transfusion(s)
If yes, when? _____
☐ Blood clotting problems/disorders
☐ Blood borne such as HIV/AIDS
☐ Blood borne such as Hepatitis B or C
☐ Cancer, type_____

**Musculoskeletal:** ☐ No problems
☐ Joint Pain
☐ Back Pain
☐ Other_____

**Neurological:** ☐ No problems
☐ Migraines
☐ Other_____

**Respiratory:** ☐ No problems
☐ Asthma
☐ Lung clot or pulmonary embolism (PE)
☐ Other_____

**Psychological:** ☐ No problems
☐ Anxiety
☐ Depression
☐ Other_____

**Vascular:** ☐ No problems
☐ Blood clot or deep vein thrombosis (DVT)

**Other:**
☐ Any metallic foreign objects in your body
If yes, where? _____

**Additional comments:**
_____
_____
_____

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**ALLERGY HISTORY:** ☁ No known allergies

Allergies including medications, dye, iodine, shellfish, latex, and your reaction.

| Allergy | Reaction | Allergy | Reaction |
|---|---|---|---|
| Allergy | Reaction | Allergy | Reaction |

**MEDICATIONS:** ☁ None

Medications including over the counter, herbals and supplements.

| Medication Name: | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |

**(PRACTITIONER USE ONLY)**

Notes:_____

_____

_____

Signature: _____