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)**

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)

_____

_____

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:
_____
_____
_____

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

(PRACTITIONER USE ONLY)

Notes:_____

_____

_____

Signature: _____