

\_\_\_\_\_  
Name

\_\_\_\_\_  
Age

\_\_\_\_\_  
Date

## UFE Patient History Questionnaire

**Referred to Dr. Fischer by:**

**When were you first diagnosed with uterine fibroids (month/year)?**

**How were you diagnosed?** *(Please circle one)*

- Routine Pelvic Exam
- Ultrasound
- Both

**What symptoms, if any, were you having at the time of the initial diagnosis?** *(Please circle all that apply)*

- None
- Heavy menstrual periods
- Urinary frequency
- Pelvic pain
- Pelvic pressure
- Constipation
- Back pain
- Painful intercourse
- Excessive menstrual cramping and pain
- Other:

**What symptoms, if any, are you having now?** *(Please circle all that apply)*

- None
- Heavy menstrual periods
- Urinary frequency
- Pelvic pain
- Pelvic pressure
- Constipation
- Back pain
- Painful intercourse
- Excessive menstrual cramping and pain
- Other:

**Have your symptoms been progressive (getting worse)?** Yes or No

**What symptom is causing the most problems?**

**Have you ever been treated for your fibroids in the past? Yes or No**

If Yes, please circle all that apply and specify the month/year of treatment.

Surgery:                    Myomectomy (open)  
                                  Laparoscopic surgery  
                                  Hysteroscopic surgery

Hormone therapy:    Birth control pills  
                                  Lupron injections

Other:

Date(s) of treatment:

**Please tell us about your menstrual periods:**

Are your menstrual periods regular or irregular?

How often do they occur? *(Please circle one)*

Monthly  
Every \_\_\_\_\_ days  
Other: *(explain)*

How long do they last (# days)?

What days are heaviest?

On the heaviest days, how often do you change tampons/pads?

Do you ever pass blood clots?  
If so, are they small, medium or large?

**Have you ever been diagnosed with anemia (low blood levels)? Yes or No**

If Yes, have you ever had a blood transfusion? Yes or No

If Yes, when did you have a blood transfusion?

**Do you have any desire to maintain fertility (have children)? Yes or No**

**Have you ever had problems with infertility? Yes or No**

If Yes, please explain.

**How many times have you been pregnant?**

**How many children do you have?** Please specify the genders and ages of your children:

Were your children delivered vaginally or by c-section?

Did you have any complications with the pregnancies or deliveries? Yes or No

If Yes, please explain.

**Have you ever had a pelvic Ultrasound?** Yes or No

If Yes, when and where was it performed?

**Have you ever had a pelvic MRI?** Yes or No

If Yes, when and where was it performed?

**Are you allergic to Iodine or X-Ray Contrast Dye?** Yes or No

**Do you have any metallic foreign objects in your body?** Yes or No

If Yes, please describe.

**Are you claustrophobic?** Yes or No

**Who is your gynecologist? How long have you seen him/her?**

Please include name, address and phone number, if applicable.

**When was your last routine gynecological exam** (month/year)?

**When was your last routine PAP smear** (month/year)?

Where was it performed?

Was it normal or abnormal?

**Have you ever had an abnormal PAP smear?** Yes or No

If Yes, when?

**Have you ever had an Endometrial biopsy (EMB)?** Yes or No

If Yes, when? Was it normal or abnormal?

**Have you ever had a sexually transmitted disease?** Yes or No

If Yes, please specify dates and treatments (if any):

