

FIBROID HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name (Last, First, M.I.):		DOB:	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
How did you hear about us? <input type="checkbox"/> Dr. Referred <input type="checkbox"/> Internet <input type="checkbox"/> Radio <input type="checkbox"/> Family/Friend <input type="checkbox"/> Other			
Referring doctor:		Gynecologist:	
Pharmacy:		Pharmacy Phone Number:	
HISTORY OF PRESENT ILLNESS: (check all that apply)			
Reason for office visit (primary problem):			
<input type="checkbox"/> Heavy menstrual cycles	<input type="checkbox"/> Flooding or gushing	<input type="checkbox"/> Passing large clots	
CYCLES: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	Length: _____ Days	Tampons / Pads per day: _____	
<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Cramps	<input type="checkbox"/> During cycle	<input type="checkbox"/> Daily
<input type="checkbox"/> Pelvic pressure	<input type="checkbox"/> Diagnosed with anemia		
<input type="checkbox"/> Increased urinary frequency	<input type="checkbox"/> Prior iron therapy		
<input type="checkbox"/> Urinating at night	<input type="checkbox"/> Prior blood transfusion		
<input type="checkbox"/> Painful sexual intercourse	<input type="checkbox"/> Feel tired, weak, or lethargic		
<input type="checkbox"/> Constipation	<input type="checkbox"/> Experience lightheadedness or dizziness		
<input type="checkbox"/> Leg pain or swelling	<input type="checkbox"/> Suffer from migraine headaches		
<input type="checkbox"/> Increased abdominal girth	<input type="checkbox"/> Hair loss or brittle hair		
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Crave or chew ice		
PRIOR TREATMENT FOR UTERINE FIBROIDS: (check all that apply)			
<input type="checkbox"/> None	<input type="checkbox"/> Myomectomy	<input type="checkbox"/> Laparoscopy	
<input type="checkbox"/> Hysteroscopy	<input type="checkbox"/> Prior UFE / UAE	<input type="checkbox"/> Birth control pills	
<input type="checkbox"/> IUD	<input type="checkbox"/> Lupron Date: _____	<input type="checkbox"/> Depo-Provera	
FERTILITY HISTORY			
Pregnancies _____	Miscarriages _____	Abortions _____	
Last Pap Smear: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Endometrial Biopsy: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Date of Last GYN Exam: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Planning Future Pregnancy:	<input type="checkbox"/> Undecided	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEDICAL HISTORY						
<input type="checkbox"/> COPD	<input type="checkbox"/> Cancer		<input type="checkbox"/> Heart Disease			
<input type="checkbox"/> Peripheral Arterial Disease	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Blood Clot / DVT			
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease		<input type="checkbox"/> Pulmonary Embolus			
<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Blood Clotting Disorder		<input type="checkbox"/> HIV / AIDS			
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sexually Transmitted Disease		<input type="checkbox"/> Other:			
Surgeries						
Year	Operation			Hospital		
FAMILY HISTORY:						
MEDICATIONS:						
MEDICATION ALLERGIES:						
		<input type="checkbox"/> No Known Drug Allergies		<input type="checkbox"/> IV Contrast Allergy		
SOCIAL HISTORY						
Do you smoke	<input type="checkbox"/> Yes			<input type="checkbox"/> No		
Former smoker?	<input type="checkbox"/> Yes			<input type="checkbox"/> No		
If former smoker:	Years smoked?			Year Quit?		
Packs per day?	<input type="checkbox"/> 0	<input type="checkbox"/> <1	<input type="checkbox"/> 1 - 2	<input type="checkbox"/> 2 - 3	<input type="checkbox"/> > 3	
Alcoholic drinks per day?	<input type="checkbox"/> 0	<input type="checkbox"/> 1 - 2	<input type="checkbox"/> 2 - 3	<input type="checkbox"/> 3 - 4	<input type="checkbox"/> > 4	
Occupation:						

CURRENT SYMPTOMS

GENERAL <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain	GASTROINTESTINAL <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea and Vomiting	NEUROLOGIC <input type="checkbox"/> Restless Legs <input type="checkbox"/> Numbness or Tingling <input type="checkbox"/> Headaches (Migraines) <input type="checkbox"/> Dizziness / Lightheaded <input type="checkbox"/> Difficulty Walking
EYES <input type="checkbox"/> Change in Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Pain	GENITOURINARY <input type="checkbox"/> Increased Urination <input type="checkbox"/> Urinating at Night <input type="checkbox"/> Bloody Urine <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Heavy Periods	PSYCHIATRIC <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Irritability <input type="checkbox"/> Thoughts of Suicide
EARS, NOSE, THROAT <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ear Pain <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sore Throat	MUSCULOSKELETAL <input type="checkbox"/> Leg Pain <input type="checkbox"/> Leg Swelling <input type="checkbox"/> Back Pain	ENDOCRINE <input type="checkbox"/> Frequent Thirst <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Brittle Hair <input type="checkbox"/> Crave Ice <input type="checkbox"/> Hair Loss
CARDIOVASCULAR <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Prior DVT (Blood Clot) <input type="checkbox"/> Heart Defect	SKIN <input type="checkbox"/> Wounds on Feet <input type="checkbox"/> Skin Changes <input type="checkbox"/> Skin Rashes or Itching	OTHER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
RESPIRATORY <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing	HEMATOLOGIC <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Blood Clots	

DALLAS

FIBROID CENTER

Listed below are symptoms experienced by women who have uterine fibroids. Please consider each symptom as it relates to your uterine fibroids or menstrual cycle. Each question asks how much distress you have experienced from each symptom during the previous 3 months. There are no right or wrong answers. Please be sure to answer every question by checking the most appropriate box. If a question does not apply to you, please mark "not at all" as a response.

During the previous 3 months, how distressed were you by:	Not at all	A little bit	Some-what	A great deal	A very great deal
1. Heavy bleeding during your menstrual period	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. Passing blood clots during your menstrual period	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. Fluctuation in the duration of your menstrual period compared to your previous cycle	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. Fluctuation in the length of your monthly cycle compared to your previous cycles	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. Feeling tightness or pressure in your pelvic area	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6. Frequent urination during the daytime hours	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. Frequent nighttime urination	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. Feeling fatigued	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

The following questions ask about your feelings and experiences regarding the impact of uterine fibroid symptoms on your life. Please consider each question as it relates to your experiences with uterine fibroids during the previous 3 months. There are no right or wrong answers. Please be sure to answer every question by checking the most appropriate box. If the question does not apply to you, please check "none of the time" as your option.

During the previous 3 months, how often have your symptoms related to uterine fibroids:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
9. Made you feel anxious about the unpredictable onset or duration of your periods?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. Made you anxious about traveling?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
11. Interfered with your physical activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
12. Cause your to feel worn out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
13. Made you decrease the amount of time you spent on exercise or other physical activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
14. Made you feel as if you are not in control of your life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
15. Made you concerned about soiling underclothes?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
16. Made you feel less productive?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

DALLAS

FIBROID CENTER

During the previous 3 months, how often have your symptoms related to uterine fibroids:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
17. Caused you to feel drowsy or sleepy during the day?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
18. Made you feel self-conscious of weight gain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
19. Made you feel that it was difficult to carry out your usual activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
20. Interfered with your social activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
21. Made you feel self-conscious about the size and appearance of your stomach?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
22. Made you concerned about soiling bed linen?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
23. Made you feel sad, discouraged, or hopeless?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
24. Made you feel down-hearted and blue?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
25. Made you feel wiped out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
26. Caused you to be concerned or worried about your health?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
27. Caused you to plan activities more carefully?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
28. Made you feel inconvenienced about always carrying extra pads, tampons, and clothing to avoid accidents?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
29. Caused you embarrassment?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
30. Made you feel uncertain about your future?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
31. Made you feel irritable?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
32. Made you concerned about soiling outer clothes?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
33. Affected the size of clothing you wear during your periods?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
34. Made you feel that you are not in control of your health?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
35. Made you feel weak as if energy was drained from your body?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
36. Diminished your sexual desire?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
37. Caused you to avoid sexual relations?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5