GEORGIA FIBROIDS

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: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
How did you hear about us? ❑ Dr. Referred ❑ Internet ❑ Radio ❑ Family/Friend ❑ Other	
Referring doctor:	**Gynecologist:**
Pharmacy:	**Pharmacy Phone Number:**

HISTORY OF PRESENT ILLNESS: (check all that apply)

Reason for office visit (primary problem):

☐ Heavy menstrual cycles	☐ Flooding or gushing	☐ Passing large clots	
CYCLES: ☐ Regular ☐ Irregular	Length: _____ Days	Tampons / Pads per day: _____	
☐ Pelvic pain	☐ Cramps	☐ During cycle	☐ Daily
☐ Pelvic pressure	☐ Diagnosed with anemia		
☐ Increased urinary frequency	☐ Prior iron therapy		
☐ Urinating at night	☐ Prior blood transfusion		
☐ Painful sexual intercourse	☐ Feel tired, weak, or lethargic		
☐ Constipation	☐ Experience lightheadedness or dizziness		
☐ Leg pain or swelling	☐ Suffer from migraine headaches		
☐ Increased abdominal girth	☐ Hair loss or brittle hair		
☐ Low back pain	☐ Crave or chew ice		

PRIOR TREATMENT FOR UTERINE FIBROIDS: (check all that apply)

☐ None	☐ Myomectomy	☐ Laparoscopy
☐ Hysteroscopy	☐ Prior UFE / UAE	☐ Birth control pills
☐ IUD	☐ Lupron Date:	☐ Depo-Provera

FERTILITY HISTORY

Pregnancies _____	Miscarriages _____	Abortions _____	
Last Pap Smear: _____	☐ Normal	☐ Abnormal	
Endometrial Biopsy: _____	☐ Normal	☐ Abnormal	
Date of Last GYN Exam: _____	☐ Normal	☐ Abnormal	
Planning Future Pregnancy:	☐ Undecided	☐ Yes	☐ No

GEORGIA FIBROIDS

MEDICAL HISTORY		
☐ COPD	☐ Cancer	☐ Heart Disease
☐ Peripheral Arterial Disease	☐ Hepatitis	☐ Blood Clot / DVT
☐ Diabetes	☐ Kidney Disease	☐ Pulmonary Embolus
☐ Migraine Headaches	☐ Blood Clotting Disorder	☐ HIV / AIDS
☐ High Blood Pressure	☐ Sexually Transmitted Disease	☐ Other:

Surgeries		
Year	Operation	Hospital

FAMILY HISTORY:

MEDICATIONS:

MEDICATION ALLERGIES:	☐ No Known Drug Allergies	☐ IV Contrast Allergy

SOCIAL HISTORY					
Do you smoke	☐ Yes			☐ No	
Former smoker?	☐ Yes			☐ No	
If former smoker:	Years smoked?			Year Quit?	
Packs per day?	☐ 0	☐ <1	☐ 1 - 2	☐ 2 - 3	☐ > 3
Alcoholic drinks per day?	☐ 0	☐ 1 - 2	☐ 2 - 3	☐ 3 - 4	☐ > 4
Occupation:					

GEORGIA FIBROIDS

CURRENT SYMPTOMS

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain

EYES
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Pain

EARS, NOSE, THROAT
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Nose Bleeds
- ☐ Sore Throat

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitaions
- ☐ Prior DVT (Blood Clot)
- ☐ Heart Defect

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea and Vomiting

GENITOURINARY
- ☐ Increased Urination
- ☐ Urinating at Night
- ☐ Bloody Urine
- ☐ Pelvic Pain
- ☐ Heavy Periods

MUSCULOSKELETAL
- ☐ Leg Pain
- ☐ Leg Swelling
- ☐ Back Pain

SKIN
- ☐ Wounds on Feet
- ☐ Skin Changes
- ☐ Skin Rashes or Itching

HEMATOLOGIC
- ☐ Easy Bleeding
- ☐ Easy Bleeding
- ☐ Blood Clots

NEUROLOGIC
- ☐ Restless Legs
- ☐ Numbness or Tingling
- ☐ Headaches (Migraines)
- ☐ Dizziness / Lightheaded
- ☐ Difficulty Walking

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Thoughts of Suicide

ENDOCRINE
- ☐ Frequent Thirst
- ☐ Frequent Urination
- ☐ Brittle Hair
- ☐ Crave Ice
- ☐ Hair Loss

OTHER
- ☐
- ☐
- ☐
- ☐
- ☐

GEORGIA FIBROIDS

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	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Passing blood clots during your menstrual period	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Fluctuation in the duration of your menstrual period compared to your previous cycle	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Fluctuation in the length of your monthly cycle compared to your previous cycles	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Feeling tightness or pressure in your pelvic area	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Frequent urination during the daytime hours	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Frequent nighttime urination	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. Feeling fatigued	☐ 1	☐ 2	☐ 3	☐ 4	☐ 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?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. Made you anxious about traveling?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11. Interfered with your physical activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12. Cause your to feel worn out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13. Made you decrease the amount of time you spent on exercise or other physical activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
14. Made you feel as if you are not in control of your life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
15. Made you concerned about soiling underclothes?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
16. Made you feel less productive?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

GEORGIA FIBROIDS

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?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
18. Made you feel self-conscious of weight gain?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
19. Made you feel that it was difficult to carry out your usual activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
20. Interfered with your social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
21. Made you feel self-conscious about the size and appearance of your stomach?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
22. Made you concerned about soiling bed linen?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
23. Made you feel sad, discouraged, or hopeless?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
24. Made you feel down-hearted and blue?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
25. Made you feel wiped out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
26. Caused you to be concerned or worried about your health?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
27. Caused you to plan activities more carefully?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
28. Made you feel inconvenienced about always carrying extra pads, tampons, and clothing to avoid accidents?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
29. Caused you embarrassment?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
30. Made you feel uncertain about your future?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
31. Made you feel irritable?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
32. Made you concerned about soiling outer clothes?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
33. Affected the size of clothing you wear during your periods?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
34. Made you feel that you are not in control of your health?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
35. Made you feel weak as if energy was drained from your body?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
36. Diminished your sexual desire?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
37. Caused you to avoid sexual relations?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5