ST. JOSEPH
HOSPITAL

172 Kinsley Street Nashua, N.H. 03060

UTERINE FIBROID EMBOLIZATION
Patient Information Form

OB/GYN HISTORY:

What symptoms are you experiencing due to the presence of fibroids?
(Circle the response that most closely reflects the severity of your symptoms)

	Not at all	Very Mild		Moderate		Very severe	Duration
Abnormal bleeding	0	1	2	3	4	5	____ months
Menstrual cramping	0	1	2	3	4	5	____ months
Pelvic pain	0	1	2	3	4	5	____ months
Frequent urination	0	1	2	3	4	5	____ months
Abdominal bloating	0	1	2	3	4	5	____ months
Pain during intercourse	0	1	2	3	4	5	____ months

Other (Please describe)____

Which one item listed above describes your most significant symptom?___________________

Menstrual History:

Are you postmenopausal ☐ Yes ☐ No

What was the first date of your last menstrual period? ____________

Are periods regular? (22-35 days) ☐ Yes ☐ No

Number of days in your cycle __________

How many pads or tampons used during the heaviest day of your period? __________

Do you bleed between periods? ☐ Yes ☐ No

Do you pass clots? ☐ Yes ☐ No

Could you be pregnant? ☐ Yes ☐ No

Birth Control History:

Are you heterosexually active? ☐ Yes ☐ No

If yes, what type of birth control do you use?

☐ None
☐ Condoms
☐ Oral contraceptives (“the pill”)
☐ IUD
☐ Diaphragm
☐ Injectable/Implantable
☐ Tubal ligation (“tubes tied”)
☐ Oopherectomy (“ovaries removed”)
☐ Partner vasectomy

If you have ever taken birth control medication, how long have you been off of it? _________

Pregnancy History:

Number of pregnancies ____

Number of miscarriages ____

Number of tubal (ectopic) pregnancies ____

Number of live births _____

Number of induced abortions _____

Number of cesarean sections _____

Are you planning on having children in the future?

☐ Yes, likely within the next 2 years
☐ Would like to keep this option open
☐ No

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Do you consider yourself infertile? ☐ Yes ☐ No

If yes, have you tried or had any of the following?
- ☐ Previous treatment for infertility
- ☐ Unprotected sex for 1 year without pregnancy
- ☐ 3 or more consecutive miscarriages

GYN Disorders:

Please indicate whether you have had any of the following gynecologic disorders:

Endometriosis	☐ Yes	☐ No	Pelvic Inflammatory Disease	☐ Yes	☐ No
Pelvic adhesions	☐ Yes	☐ No	Adenomyosis	☐ Yes	☐ No

Other (Please describe)

____

____

Previous Diagnostic Tests:

Please indicate whether you have had any of the following diagnostic tests:

- ☐ Ultrasound Date Performed: ____________
- ☐ CAT scan Date Performed: ____________
- ☐ MRI Date Performed: ____________
- ☐ PAP smear Date Performed: ____________
- ☐ Endometrial biopsy Date performed: ____________

Prior Treatment of Symptoms:

☐ Lupron injections	Within the last 3 months? ☐ Yes ☐ No
How many injections? _________	Last injection (date) ____________________
☐ Oral contraceptives	Within the last 3 months? ☐ Yes ☐ No
☐ Non-steroidal anti-inflammatory drugs (ie, Advil)	Within the last 3 months? ☐ Yes ☐ No
☐ Depo-provera	Within the last 3 months? ☐ Yes ☐ No
☐ Other (Provera, Aygestin, Megase, Synarel)	Within the last 3 months? ☐ Yes ☐ No

GYN Surgical History:

Have you had any of the following gynecological procedures? (Please note dates)

- ☐ Myomectomy Date Performed: ____________
- ☐ Myolysis Date Performed: ____________
- ☐ D & C Date Performed: ____________
- ☐ Ovarian cysterectomy Date Performed: ____________
- ☐ Endometrial ablation Date Performed: ____________
- ☐ Tubal ligation Date Performed: ____________
- ☐ Oopherectomy Date Performed: ____________

HOW DID YOU FIRST HEAR ABOUT THIS PROCEDURE?

☐ Family Physician	☐ Specialist	☐ Family/Friend	☐ Newspaper/Magazine
☐ Public radio	☐ Internet	☐ Television	☐ Other

Form reviewed by: ____ Date: ________________

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