FIBROID INSTITUTE DALLAS

Name_____ Date_____

Gynecology History

Number of pregnancies _____
Number of births _____
Number of miscarriages _____
How many days does your period last _____
How many days between periods _____
Number of pads per day _____
Number of tampons per day _____

Fertility (check one)

- ❒ I don't want to get pregnant
- ❒ I am currently trying to get pregnant
- ❒ I plan to get pregnant in the future
- ❒ I want to get pregnant in the future but don't have any current plans
- ❒ I don't know if I want to get pregnant

Menopause Status

- ❒ I'm not in menopause
- ❒ I'm in menopause
- ❒ I've started having menopause symptoms
- ❒ I don't know if I'm in menopause

Last Mentrual Period

- ❒ This month
- ❒ Last month
- ❒ Continual bleeding
- ❒ Within the past 6 months
- ❒ Last year
- ❒ More than a year ago

Birth Control

- ❒ None
- ❒ Abstinence
- ❒ Condom
- ❒ Tubal ligation
- ❒ Vasectomy
- ❒ IUD
- ❒ Birth control pills
- ❒ Hormone implant

Fibroid Family History

- ❒ Mother has fibroids
- ❒ Mother had hysterectomy
- ❒ Sister has fibroids
- ❒ Aunt/Cousin has fibroids

Signs and Symptoms (check all that apply)

- ❒ Heavy menstrual periods
- ❒ Passing clots
- ❒ Spotting between periods
- ❒ Spotting after intercourse
- ❒ Pain during periods
- ❒ Pain between periods
- ❒ Pain during intercourse
- ❒ Pain after intercourse
- ❒ Pelvic pressure
- ❒ Urinary frequency
- ❒ Urinary urgency
- ❒ Urinary incontinence
- ❒ Back pain
- ❒ Pain radiating down legs
- ❒ Constipation
- ❒ Varicose veins

(Symptoms continued on next page)

Signs and Symptoms (check all that apply)

- ❒ Anemia
- ❒ Taking iron supplements
- ❒ Iron infusion
- ❒ Blood transfusion
- ❒ Hot flashes
- ❒ Night sweats
- ❒ Symptoms have lasted months
- ❒ Symptoms have lasted years
- ❒ Symptoms getting worse
- ❒ Previously diagnosed with fibroids

Priorities (check one)

- ❒ My top priority is to relieve my symptoms
- ❒ My top priority is to avoid surgery
- ❒ My top priority is to get pregnant

Surgery Priorities (check one)

- ❒ I will not have surgery
- ❒ I will have surgery if needed
- ❒ I want surgery

Uterus Priorities (check one)

- ❒ I do not want my uterus removed
- ❒ I do not mind losing my uterus
- ❒ I want my uterus removed

Gynecologist: _____

Primary Care Doc: _____

You can discuss my care with my gynecologist or other doctors ❒ Yes ❒ No

Prior Fibroid Treatment	Year	Other pelvic surgery for	Year
❒ None			
❒ Hormone medication	_____	❒ None	_____
❒ IUD	_____	❒ C - section	_____
❒ Myomectomy	_____	❒ Endometriosis	_____
❒ Endometrial ablation	_____	❒ Ovarian cyst	_____
❒ Uterine fibroid embolization	_____	❒ Fallopian tube	_____
❒ Acessa	_____	❒ _____	

Imaging

❒ Ultrasound shows fibroids ❒ CT shows fibroids ❒ MRI shows fibroids

Which facility did the imaging _____

❒ Right handed ❒ Left handed

Current Medications and Dose ❒ None

Pharmacy

Name _____

Phone _____

City _____

Past Medical History (check all that apply) ❒ None

- ❒ Allergies
- ❒ Arthritis
- ❒ Anemia
- ❒ Asthma
- ❒ Atherosclerosis
- ❒ Atrial fibrillation
- ❒ Bariatric surgery
- ❒ Blood disorder
- ❒ Blood clots in lungs
- ❒ Cancer
- ❒ Carpal tunnel
- ❒ Chest pain
- ❒ Cirrhosis
- ❒ COPD/Emphysema
- ❒ Congestive heart failure
- ❒ Deep vein thrombosis
- ❒ Diabetes
- ❒ Dialysis
- ❒ Diverticulitis
- ❒ Endometriosis
- ❒ Gallstones
- ❒ GERD/Ulcer
- ❒ Heart disease
- ❒ Heart murmer
- ❒ Hepatitis B or C
- ❒ Hernia
- ❒ High cholesterol
- ❒ High thyroid
- ❒ HIV
- ❒ Hypertension
- ❒ Keloids
- ❒ Kidney disease
- ❒ Kidney stones
- ❒ Leg pain
- ❒ Liver disease
- ❒ Low thyroid
- ❒ Lupus
- ❒ Ovarian cyst
- ❒ Pacemaker
- ❒ Pneumonia
- ❒ Polycystic ovaries
- ❒ Psoriasis
- ❒ Rheumatoid
- ❒ Seizures
- ❒ Sleep apnea
- ❒ Stroke
- ❒ _____
- ❒ _____

Drug Allergies

❒ None

_____

_____

_____

_____

_____

_____

Past Surgical History ❒ None Year

_____ _____

_____ _____

_____ _____

_____ _____

Prior Hospitalizations ❒ None Year

_____ _____

_____ _____

_____ _____

_____ _____

Tobacco Use

- ❒ Never smoked
- ❒ Former smoker
- ❒ Current every day smoker
- ❒ Current occassional smoker

Marital Status

- ❒ Single
- ❒ Married
- ❒ Significant other
- ❒ Divorced
- ❒ Widowed

Alcohol / Drug Use

- ❒ Never drink alcohol
- ❒ Light alcohol use (0-2 days/week)
- ❒ Moderate alcohol use (3-4 days/week)
- ❒ Heavy alcohol use (5-7 days/week)
- ❒ Alcoholic in recovery
- ❒ Never use recreational drugs
- ❒ Marijuana occasionally
- ❒ Marijuana daily
- ❒ Cocaine use
- ❒ Other recreational drug
- ❒ Intravenous drug use

Review of Systems (check all the symptoms you have)

General

- ❒ Recent weight loss
- ❒ Recent weight gain
- ❒ Fever
- ❒ Chills
- ❒ Fatigue
- ❒ No symptoms

Allergy

- ❒ Itching
- ❒ Rash
- ❒ Postnasal drip
- ❒ Sneezing
- ❒ No symptoms

Eyes

- ❒ Wear glasses
- ❒ Contact lenses
- ❒ Double vision
- ❒ Cataracts
- ❒ Flashes of light
- ❒ Eye pain
- ❒ No symptoms

Ear Nose Throat

- ❒ Hearing loss
- ❒ Nose bleeds
- ❒ Ringing in the ears
- ❒ Voice change
- ❒ No symptoms

Endocrine

- ❒ Excessive thirst
- ❒ Cold intolerance
- ❒ Heat intolerance
- ❒ No symptoms

Respiratory

- ❒ Cough
- ❒ Short of breath at rest
- ❒ Wheezing
- ❒ Difficulty breathing
- ❒ No symptoms

Cardiovascular

- ❒ Chest pain
- ❒ Irregular heart beat
- ❒ Palpitations
- ❒ Leg pain when walking
- ❒ No symptoms

Gastrointestinal

- ❒ Nausea
- ❒ Vomiting
- ❒ Diarrhea
- ❒ No symptoms

Hematology

- ❒ Easy bruising
- ❒ Night sweats
- ❒ Swollen glands
- ❒ Easy bleeding
- ❒ No symptoms

Genitourinary

- ❒ Blood in urine
- ❒ Painful urination
- ❒ Urine leakage
- ❒ Hard to pee
- ❒ No symptoms

Musculoskeletal

- ❒ Painful joints
- ❒ Swollen joints
- ❒ Joint stiffness
- ❒ Muscle aches
- ❒ No symptoms

Skin

- ❒ Acne
- ❒ Rash
- ❒ Discoloration
- ❒ No symptoms

Neurologic

- ❒ Dizziness
- ❒ Headache
- ❒ Memory loss
- ❒ Tingling
- ❒ Numbness
- ❒ Loss of strength
- ❒ No symptoms

Psychiatric

- ❒ Anxiety
- ❒ Depression
- ❒ Stress
- ❒ Mood Swings
- ❒ No symptoms

Height _____

Weight _____