FIBROID INSTITUTE DALLAS

RESET

NEW PATIENT INTAKE FORM

Information

Name

Date of birth

How did you hear about us

- ☐ Gynecologist
- ☐ Internet search
- ☐ Friend or family
- ☐ Event
- ☐ TV
- ☐ Other doctor
- ☐ Social media
- ☐ Radio
- ☐ Print ad
- ☐ Insurance
- ☐ Other: _____

Care Team

Pharmacy name

Pharmacy phone number

Preferred lab ☐ No preference

Imaging center name ☐ No preference

Imaging center city

Gynecologist ☐ None

Primary care doctor ☐ None

Other doctor

Can we share you record with other doctors using Athena

☐ Yes ☐ No

Allergies

Drug allergies ☐ None

Past Medical History

- ☐ 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
- ☐ Other
- ☐ _____
- ☐ _____

North Dallas
12840 Hillcrest Road, Suite E104,
Dallas, TX 75230

South Dallas
1010 East Wheatland Road, Suite 200
Duncanville, TX 75116

Connect with Us
Phone 214-838-6440, Fax 214-838-6441
WWW.FIBROIDFREE.COM

Past Surgical History

☐ None

Surgery	Year

Medications

☐ None

Current medication	Dose

Social History

Are you a caregiver ☐ Yes ☐ No

Notes

_____

Tobacco Use

☐ Never smoked ☐ Former smoker

☐ Current every day smoker

☐ Current occasional smoker

How many years have you smoked: _____

How many packs per day do/did you smoke: _____

How many years since your last cigarette

☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16+

Alcohol use

☐ None ☐ Occasional

☐ Moderate ☐ Heavy

☐ 1-2 times per week

☐ 3-4 times per week

☐ 5-7 times per week

How many days in the past year have you consumed 5 or more drinks:

_____

Recreational drugs

Do you use recreational drugs

☐ Yes ☐ No

☐ Marijuana occasionally ☐ Marijuana daily

☐ Cocaine ☐ Other recreational drugs

☐ IV drugs

Are you currently employed

☐ Yes ☐ No

Occupation

_____

Relationship status

☐ Single ☐ Married

☐ Significant other ☐ Divorced

☐ Separated ☐ Widowed

Would you accept a blood in an emergency

☐ Yes ☐ No

What is your exercise level

☐ None ☐ Occasional

☐ Moderate ☐ Heavy

How many times per week do you exercise

☐ 1-2 ☐ 3-4 ☐ 5-7

Have you recently traveled abroad

☐ Yes ☐ No

Have you been to a high risk covid area

☐ Yes ☐ No

Have you had close contact with someone with covid

☐ Yes ☐ No

Are you blind or visually impaired

☐ Yes ☐ No

Are you deaf or do you have impaired hearing

☐ Yes ☐ No

Do you have transportation difficulties

☐ Yes ☐ No

Which of your hands is dominant

☐ Left ☐ Right

Fibroid Family History

- [ ] None
- [ ] Mother has fibroids
- [ ] Aunt/cousin has fibroids
- [ ] Mother had hysterectomy
- [ ] Sister has fibroids

Review of systems

Constitutional

- [ ] Fatigue
- [ ] Fever
- [ ] Chills
- [ ] Recent weight loss
- [ ] Recent weight gain
- [ ] No symptoms

Skin

- [ ] Rash
- [ ] Acne
- [ ] Discoloration
- [ ] No symptoms

Eyes

- [ ] Irritation
- [ ] Vision changes
- [ ] Double vision
- [ ] Wear glasses
- [ ] Contact lenses
- [ ] No symptoms

Ear Nose Throat

- [ ] Hearing loss
- [ ] Nose/sinus problem
- [ ] Sore throat
- [ ] Snoring
- [ ] Dry mouth
- [ ] Nose bleeds
- [ ] No symptoms

Respiratory

- [ ] Short of breath
- [ ] Cough
- [ ] Sputum production
- [ ] Coughing up blood
- [ ] Wheezing
- [ ] No symptoms

Cardiovascular

- [ ] Chest pain
- [ ] Palpitations
- [ ] Leg swelling
- [ ] No symptoms

Gastrointestinal

- [ ] Heartburn
- [ ] Nausea
- [ ] Vomiting
- [ ] Abdominal pain
- [ ] Constipation
- [ ] Diarrhea
- [ ] No symptoms

Genitourinary

- [ ] Blood in urine
- [ ] Trouble urinating
- [ ] Vaginal discharge
- [ ] No symptoms

Endocrine

- [ ] Excessive thirst
- [ ] Excessive body hair
- [ ] Cold intolerance
- [ ] Heat intolerance
- [ ] No symptoms

Musculoskeletal

- [ ] Muscle aches
- [ ] Muscle weakness
- [ ] Joint pain
- [ ] Spine pain
- [ ] No symptoms

Neurologic

- [ ] Headache
- [ ] Dizziness
- [ ] Weakness
- [ ] Numbness
- [ ] Seizures
- [ ] No symptoms

Psychiatric

- [ ] Depression
- [ ] Sleep disturbance
- [ ] Panic attacks
- [ ] Anxious or nervous
- [ ] No symptoms

Hematology

- [ ] Swollen glands
- [ ] Easy bruising
- [ ] Excessive bleeding
- [ ] No symptoms

Allergy

- [ ] Runny nose
- [ ] Itching
- [ ] Hives
- [ ] Frequent sneezing
- [ ] No symptoms

Body

Height _____

Weight _____

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History of Present Illness

Pregnancy history and plans

Number of pregnancies

Number of births

Number of miscarriages

- [ ] Prior vaginal delivery
- [ ] Prior c-section
- [ ] I do not want to get pregnant
- [ ] I do not know if I want to get pregnant
- [ ] I plan to get pregnant in the future
- [ ] I am trying to get pregnant now

Notes

Birth control

- [ ] None
- [ ] Abstinence
- [ ] Condoms
- [ ] Birth control pills
- [ ] Tubal ligation
- [ ] Partner had vasectomy
- [ ] Intrauterine device (IUD)
- [ ] Subdermal implant
- [ ] Diaphragm
- [ ] Other

Notes

How long do your periods usually last

- [ ] 1-3 days/month
- [ ] 3-5 days/month
- [ ] 6-7 days/month
- [ ] 8-10 days/month
- [ ] 10-15 days/month
- [ ] Almost daily
- [ ] Daily
- [ ] Irregular length of periods
- [ ] Periods are getting longer
- [ ] Interval between periods has decreased
- [ ] Interval between periods is less than 21 days

Notes

Bleeding symptoms

- [ ] None
- [ ] Excessive bleeding during period
- [ ] Prolonged bleeding during period
- [ ] Light spotting between periods
- [ ] Heavy bleeding between periods
- [ ] Bleeding occurs during or after sex
- [ ] Anemia
- [ ] Low iron

My lowest hemoglobin was _____

My lowest hematocrit was _____

- [ ] Taking iron supplements
- [ ] I have had an iron infusion
- [ ] I have had a blood transfusion
- [ ] I am currently taking a blood thinner

Notes

How heavy is your bleeding

- [ ] Spotting
- [ ] Light
- [ ] Moderate
- [ ] Heavy
- [ ] Passing clots
- [ ] Passing dime sized clots
- [ ] Passing quarter sized clots
- [ ] Passing egg sized clots
- [ ] Using 8 or more pads or tampons daily
- [ ] Changing pad or tampon every 1-2 hours

Using _____ pads per 24 hours

Using _____ tampons per 24 hours

- [ ] Requires double protection
- [ ] Requires getting up at night
- [ ] Bleeding through onto clothes/sheets/seats
- [ ] Bleeding interferes with daily activities
- [ ] Bleeding has caused me to miss work

Notes

History of Present Illness (cont.)

How long have your cycles been heavy

- ☐ Past 1-5 periods
- ☐ Past 6-12 periods
- ☐ Occasional periods
- ☐ Every period
- ☐ Since my periods first started
- ☐ Past 2-5 years
- ☐ This is a typical bleeding pattern for me
- ☐ This is an atypical bleeding pattern for me

Notes

Location of pain

- ☐ None
- ☐ Pelvic pain
- ☐ Abdominal pain
- ☐ Lower back pain
- ☐ Right lower quadrant
- ☐ Left lower quadrant
- ☐ Right flank pain
- ☐ Left flank pain
- ☐ Right leg pain
- ☐ Left leg pain
- ☐ Pain occurs during or after sex

Notes

How bad is your pain

- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Intense
- ☐ Disabling
- ☐ Pain interferes with daily activities
- ☐ Pain has caused me to miss work
- ☐ Pain requires staying in bed

Notes

Duration of symptoms

- ☐ Pain during periods
- ☐ Pain between periods
- ☐ Symptoms have lasted weeks
- ☐ Symptoms have lasted months
- ☐ Symptoms have lasted years

Notes

Current therapies include

- ☐ None
- ☐ Ibuprofen/NSAIDs
- ☐ Tylenol
- ☐ Aspirin
- ☐ Muscle relaxants
- ☐ Oral narcotics
- ☐ Heating pad

Other

- ☐ My pain is not relieved by medication
- ☐ My pain is partly relieved by medication
- ☐ My pain is relieved by medication

Notes

Other conditions

- ☐ None
- ☐ Endometriosis
- ☐ Endometrial polyps
- ☐ Adenomyosis
- ☐ Polycystic ovary syndrome
- ☐ Other

Notes

Associated symptoms

- ☐ None
- ☐ Fatigue
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Urinary leakage
- ☐ Bloating
- ☐ Constipation
- ☐ Vaginal discharge
- ☐ Vaginal itching/irritation
- ☐ Moody/irritable/depressed prior to period
- ☐ Headache with period

Notes

History of Present Illness (cont.)

Menopause status

- ☐ I am not in menopause
- ☐ I do not know if i am in menopause
- ☐ I have started having menopause symptoms (hot flashes)
- ☐ I am in menopause

My last period was

- ☐ This month
- ☐ Last month
- ☐ Within the past 6 months
- ☐ Within the past year
- ☐ More than a year ago
- ☐ I am currently on hormone replacement therapy

Notes

Prior tests

- ☐ None
- ☐ I have had an endometrial biopsy
- ☐ I have not had an endometrial biopsy

Most recent Pap smear was

- ☐ This year
- ☐ Last year
- ☐ The year before last
- ☐ More than 2 years ago
- ☐ Ultrasound shows fibroids
- ☐ Transvaginal ultrasound shows fibroids
- ☐ CT shows fibroids
- ☐ MRI shows fibroids
- ☐ Where was MRI or CT done _____

Notes

Prior fibroid treatment

- ☐ None
- ☐ Birth control pills
- ☐ Hormone injections
- ☐ IUD (intrauterine device)
- ☐ D&C
- ☐ Endometrial ablation
- ☐ Uterine artery embolization
- ☐ Fibroid removed through cervix (hysteroscopic myomectomy)
- ☐ Fibroid removed surgically (myomectomy)
- ☐ Acessa procedures
- ☐ Sonata procedure
- ☐ Hysterectomy

Other treatment

What year were your prior fibroid treatments done

Notes

Previous pelvic surgery

- ☐ None
- ☐ C-section
- ☐ Tubal ligation
- ☐ Endometriosis surgery
- ☐ Ovarian surgery (cyst/torsion)
- ☐ Bladder surgery
- ☐ Ectopic pregnancy surgery
- ☐ Hernia repair

Other pelvic surgery

Notes

Priorities

Surgery

- ☐ I will have UFE but not surgery
- ☐ I will have surgery if necessary
- ☐ I want surgery

Uterus

- ☐ I do not want my uterus removed
- ☐ I will have a hysterectomy if necessary
- ☐ I want my uterus removed

My top priority is to

- ☐ Relieve my symptoms
- ☐ Avoid surgery
- ☐ Get pregnant

Notes

- ☐ You may speak to my other doctors about my care
- ☐ You may NOT speak to my other doctors about my care

Notes