UTERINE FIBROID HISTORY QUESTIONAIRE DATE_____

Patient Name _____

Date of Birth _____ Age _____ Race _____

OB/GYN _____

Primary Care Physician _____

Last Menstrual Period _____

Number of Pregnancies _____ Number of Births _____

HISTORY

First diagnosed with uterine fibroids _____

Medications currently taking _____

_____

Circle if you have any of the following: heart disease, cancer , high blood pressure

Previous Surgery, if yes please list type, when and where

_____

Previous Pelvis xrays (MRI, CT, Ultrasound) yes _____ no _____

If yes, where _____

SYMPTOMS

Are you experiencing any of the following symptoms:

Excessive Vaginal Bleeding Yes _____ No_____

If yes, how long _____

Increase frequency of urination Yes _____ No _____

Shortness of breath Yes _____ No _____

Pain with intercourse Yes _____ No _____

Abdominal Pain Yes _____ No _____