

MRN:
 Patient Name:

 (Patient Label)

**UTERINE FIBROID SYMPTOM & HEALTH-RELATED
 QUALITY OF LIFE QUESTIONNAIRE (UFS-QOL)**
 Interventional Radiology

Time since fibroid treatment:

- No treatment yet 3 months 6 months 9 months
 1 year 2 years 3 years

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 three 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 three months, how distressed were you by:

	Not at all 1	A little bit 2	Somewhat 3	A great deal 4	A very great deal 5
1. Heavy bleeding during your menstrual period	<input type="checkbox"/>				
2. Passing blood clots during your menstrual period	<input type="checkbox"/>				
3. Fluctuation in the duration of your menstrual period	<input type="checkbox"/>				
4. Fluctuation in the length of your monthly cycle compared to your previous cycles	<input type="checkbox"/>				
5. Feeling tightness or pressure in your pelvic area	<input type="checkbox"/>				
6. Frequent urination during the daytime hours	<input type="checkbox"/>				
7. Frequent nighttime urination	<input type="checkbox"/>				
8. Feeling fatigued	<input type="checkbox"/>				

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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 three 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 “none of the time” as your option.

During the previous three months, how often have your symptoms related to uterine fibroids?

	None of the time 1	A little of the time 2	Some of the time 3	Most of the time 4	All of the time 5
9. Made you feel anxious about the unpredictable onset or duration of your periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Made you feel anxious about traveling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Interfered with your physical activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Caused you to feel tired or worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Made you decrease the amount of time you spent on exercise or other physical activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Made you feel as if you are not in control of your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Made you concerned about soiling underclothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Made you less productive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Caused you to feel drowsy or sleepy during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Made you feel self-conscious of weight gain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Made you feel that it was difficult to carry out your usual activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Interfered with your social activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Made you feel conscious about the size and appearance of your stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Made you concerned about soiling bed linen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Made you feel sad, discouraged or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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During the previous three months, how often have your symptoms related to uterine fibroids?

	None of the time 1	A little of the time 2	Some of the time 3	Most of the time 4	All of the time 5
24. Made you feel down-hearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Made you feel wiped out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Caused you to be concerned or worried about your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Caused you to plan activities more carefully?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Made you feel inconvenienced always carrying extra pads, tampons, and clothing to avoid accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Caused you embarrassment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Made you feel uncertain about your future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Made you feel irritable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Affected the size of clothing you wear during your periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Made you feel that you are not in control of your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Made you feel weak as if energy was drained from your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Made you concerned about soiling outer clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Diminished your sexual desire?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Caused you to avoid sexual relations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____ Date _____ Time _____