UCLA Health

MRN:

Patient Name:

UTERINE ARTERY EMBOLIZATION QUESTIONNAIRE

Referred By:

Primary Care Provider:

OBGYN/Radiologist MD:

Fibroids First Diagnosed:

Fibroid Symptoms (Check all that apply):

☐ **Menstrual**
- ☐ Heavy Bleeding/Clots
- ☐ Bleeding after intercourse
- ☐ Break through Bleeding
- ☐ Pain with menstrual cycle

☐ **Urinary**
- ☐ Frequency
- ☐ Bladder Pressure
- ☐ Incontinence

☐ **Abdominal/Pelvis**
- ☐ Pressure
- ☐ Increased Girth
- ☐ Pain
- ☐ Constipation

☐ **Pain with Intercourse**

☐ **Symptoms of Menopause**
- ☐ Hot Flashes
- ☐ Other: _____

Allergies: _____

Current Meds:

For pain: _____

Contraceptive Pills ☐ Yes ☐ No

Lupron ☐ Yes ☐ No

Other: _____

Family History:

Fibroids ☐ Yes ☐ No

Other: _____

Past Gynecologic History:

Menarche Age: _____

Last Pap? _____

Abnormal Pap ☐ Yes ☐ No ☐ Unsure

Endometriosis ☐ Yes ☐ No ☐ Unsure

Adenomyosis ☐ Yes ☐ No ☐ Unsure

Pelvic Infection ☐ Yes ☐ No ☐ Unsure

IUD ☐ Yes ☐ No ☐ Unsure

OB History:

# of Pregnancies/Abortions: _____

# of Deliveries: _____

Future Pregnancy Desired:

☐ Yes ☐ No ☐ Maybe

Explain: _____

Past Medical History:

Anemia ☐ Yes ☐ No

Blood Transfusion ☐ Yes ☐ No

Iron Supplements ☐ Yes ☐ No

Other: _____

Past Surgical History:

Myomectomy ☐ Yes ☐ No

Number of abdominal surgeries: _____

Other: _____

Social History:

Married or Single? _____

# of Children _____

Work History: _____

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 _____