Advanced Radiology Services PC

Uterine Fibroid Questionnaire

Patient Name: ____
Date of Birth: ______________________
Today's Date: ______________________

When was your last menstrual period: ____

Are your menstrual cycles: ☐ Regular ☐ Irregular

Length of cycles: ______________________________________

How many previous pregnancies have you had: ___________________________________

Are you considering future pregnancies: ☐ Yes ☐ No

Have you had any of the following? (Check all that apply)

☐ Heavy Bleeding ☐ Clotting ☐ Back Pain ☐ Lower Abdominal Pain
☐ Rectal Pain ☐ Constipation ☐ Urinary Frequency ☐ Painful Intercourse
☐ Anemia Type (if known): ___________________________________

Have you ever had any gynecological infections: ☐ Yes ☐ No

Have you had any previous gynecological surgeries: ☐ Yes ☐ No
If yes, please list: ___________________________________

What therapies have you tried:
☐ Hormonal Treatment ☐ Non-Steroidal Medications (Motrin, Aleve …)

Date of last Pap smear: __________________ ☐ Normal ☐ Abnormal

Have you had an endometrial biopsy: ☐ Yes ☐ No
If yes, when: ____
If yes, what was the result: _______________________________________

Have you had any imaging or studies done: ☐ Yes ☐ No
If yes, when: ____
If yes, what did you have done:____________________________________