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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: _____