Advanced Radiology Services PC

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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: _____