FIBROID CENTER OF PENNSYLVANIA
INTERVENTIONAL ASSOCIATES
UTERINE FIBROID EMBOLIZATION

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Telephone: Home: _____ Work: _____ Cell: _____

MR#: _____ Referring Physician: _____

Consultation with Doctor: _____

STUDIES:

_____ Ultrasound: Date: _____ Location: _____ Phone #: _____

_____ MRI Date: _____ Location: _____ Phone #: _____

_____ End Biopsy: Date: _____ Location: _____ Phone #: _____

Reports Received:

_____ Ultrasound

_____ MRI

_____ Endometrial Biopsy

Lab Work: _____

Procedure Scheduled: _____

Choice of Anesthesia:

Insurance Information:

1. _____ Percent #: _____

   ID#: _____ GR#: _____ Benefits: _____

   Referral required Y/N appr. required Y/N spoke with _____ Date: _____

   Eff. Date: _____ Auth#: _____

2. _____ Percent #: _____

   ID#: _____ GR#: _____ Benefits: _____

   Referral required Y/N appr. required Y/N spoke with _____ Date: _____

   Eff. Date: _____ Auth#: _____

Other:

Fibroid Data Form

Interviewer: _____ Date: _____

Patient: _____ Patient ID#: _____

Clinical History:

Age: _____ Age of Menarche: _____ Pregnancy Hx: _____

HPI: _____

_____

_____

_____

_____

Prior Other Gyne Surgery: _____

_____

_____

Ultrasound / MRI Findings (Date): _____

_____

_____

Uterine Volume: _____

Dominant Fibroid (s) Size and Location: _____

_____

Endometrial Biopsy Date: _____ **Result: _____**

Cervical Cultures Date: _____ **Result: _____**

CBC Date: _____ Result: _____

<u>Other Medical History</u>:

PMH **ROS**

Medical Illnesses: _____ **HEENT: _____**

_____ **Heart: _____**

Surgery: _____ **Lungs: _____**

_____ **GI: _____**

Allergies: _____ **GU: _____**

Medications: _____

_____

FIBROID CENTER OF PENNSYLVANIA

INTERVENTIONAL ASSOCIATES

UTERINE FIBROID EMBOLIZATION

Registration Data:

Name: _____ Date: _____

Date of Birth: _____ SS#: _____

Age: _____ Marital Status: S D W S

Address: _____

_____

Daytime Phone #: _____ Evening Phone #: _____

Occupation: _____ Children: _____

Referring MD: _____ Phone #: _____

Other MD's: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

Primary Insurance: _____

Group #: _____ Individual ID #: _____

Precertification #: _____

Primary Insurance: _____

Group #: _____ Individual ID #: _____

Precertification #: _____

FIBROID CENTER OF PENNSYLVANIA

INTERVENTIONAL ASSOCIATES

UTERINE FIBROID EMBOLIZATION

UTERINE FIBROID EMBOLIZATION BASELINE QUESTIONNAIRE

Patient Name: _____ Date: _____

Pt. MR#: _____

Symptom Status

Menstrual Bleeding:

How would you describe the amount of menstrual bleeding that you now have:

_____ Heavy _____ Normal _____ Light _____No periods

If it is heavy, how would you describe the severity of the bleeding? (Circle the most appropriate)

Not very severe		Moderately Severe		Very Severe
1	2	3	4	5

Pelvic pain and/or pressure, urinary pressure:

Were pain, pelvic discomfort or urinary pressure a significant part of your symptoms?

_____ Yes _____No

What symptoms are you experiencing:

_____ Painful cramps during periods

_____ Pelvic, back, or leg pain or pressure at times other than during periods

_____ Frequent urination

_____ Other, please explain

How severe are these symptoms when taken together (circle the most appropriate number)

Not very severe		Moderately Severe		Very Severe
1	2	3	4	5

Impact:

On the scale of 1 - 10 below, please circle the number that most closely corresponds to the impact that your fibroid-related symptoms are having on your daily activities and overall quality of life.

No impact		Mild Impact		Moderate Impact		Substantial Impact			Severe Impact
1	2	3	4	5	6	7	8	9	10

UTERINE FIBROID EMBOLIZATION BASELINE QUESTIONNAIRE CONTINUED

Overall Health Status:

On the scale of 1 to 100 given below, with zero equal to the worst possible health and 100 being perfect health, mark an X at a value that you think most closely reflects your overall health, including consideration of the symptoms caused by your fibroids.

Pregnancy:

Have you been pregnant in the past? _____ Yes _____ No

If yes, how many times: _____

How many children do you have? _____

Which of the following statements most accurately reflects your feelings regarding future pregnancy?

_____ I am past the age of potential pregnancy (>45)

_____ I have had a tubal ligation

_____ I am not interest in future pregnancy

_____ I may be interested in future pregnancy, but I am not now trying to become pregnant

_____ I am interested in pregnancy and I am actively trying to become pregnant

Comments regarding pregnancy: _____

_____

_____

Thank you for your assistance