Florida Vascular Specialists
3 SW 129th Ave Suite 101-102, Pembroke Pines, FL 33027
T: 954-852-3831 F: 954-852-3832
E: frontdesk@floridavascularcare.com

FIBROID QUESTIONNAIRE

Patient's Name: _____

DOB: _____ **Phone Number:** _____ **Date:** _____

Name of Doctor who performs your GYNECOLOGICAL exams ☐ **OBGYN** ☐ **Family Practice**

_____

MENSTRUAL HISTORY

1. **How old were you when you first got your period?** _____
2. **When was your last menstrual period?** _____
3. **Does your period come around the same times every month?** ☐ Yes ☐ No
4. **How long do they last?** _____
5. **Do you have bleeding during periods?** ☐ Yes ☐ No
6. **Do you have heavy bleeding during your period?** ☐ Yes ☐ No
   - **If so, please rate on a scale of 0-5 (with 5 being the worst):** _____
7. **Do you have to wear both pads and tampons?** ☐ Yes ☐ No
8. **How often do you change your pads/tampons during your heaviest day?** _____
9. **Are you passing blood clots during your period?** ☐ Yes ☐ No
   - If so, are they: ☐ Quarter size ☐ Half dollar size ☐ Fist size.
10. **Do you have excessive cramping/pein with your periods?** ☐ Yes ☐ No
    - If so, please rate on a scale of 0-5 (with 5 being the worst): _____
11. **Have you been diagnosed with anemia?** ☐ Yes ☐ No
12. **Do you feel fatigued all the time?** ☐ Yes ☐ No
    - If so, please rate on a scale of 0-5 (with 5 being the worst): _____

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BULK SYMPTOMS

13. **Do you feel bloated during your periods or is your abdomen distended?** ☐ Yes ☐ No
14. **Do you feel tightness or pressure in your pelvic area even when you?**
    are off your periods? ☐ Yes ☐ No
15. **Do you have pain or bleeding with intercourse?** ☐ Yes ☐ No
    - If so, please rate on a scale of 0-5 (with 5 being the worst): _____
16. **Do you have to urinate excessively**? ☐ Yes ☐ No
    - If so, please rate on a scale of 0-5 (with 5 being the worst): _____

GYN HISTORY

17. **Have you been diagnosed with uterine fibroids by a medical professional?** ☐ Yes ☐ No
    - If so, When? _____
18. **Have you been treated for fibroids in the past?** ☐ Yes ☐ No
    If yes, please select which treatment below.
    - ☐ Birth control pills
    - ☐ IUD
    - ☐ Hormone Injections
    - ☐ Myomectomy
    - ☐ Ablation
19. **When was your last routine GYNECOLOGICAL exam?** _____
20. **When was your last PAP Smear? Where was it performed? Was it normal?** _____
21. **Have you ever had an abnormal Pap Smear?** ☐ Yes ☐ No
    - **If so, When? What was the result?** _____
22. **Have you ever had an Endometrial biopsy?** ☐ Yes ☐ No
    - **If so, When? What was the result?** _____

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OB HISTORY

23. **How many times have you been pregnant?** _____
24. **How many children do you have?** _____
25. **Have you ever had problems with infertility?** ☐ Yes ☐ No
26. **Do you plan to become pregnant in the future?** ☐ Yes ☐ No

IMAGING HISTORY

27. **Has a physician diagnosed you using:**
    - ☐ Palpation
    - ☐ Ultrasound
    - ☐ CT scan
    - ☐ MRI
28. **Are you claustrophobic?** ☐ Yes ☐ No
29. **Do you have any metal in your body?** ☐ Yes ☐ No
    - **If so, what is it and how long has it been there?** _____

How did you hear about us?

☐ Website ☐ Physician ☐ Radio ☐ Insurance List

☐ TV ☐ Event ☐ Friend ☐ Other: _____