OHSUHealth
Hillsboro Medical Center

Hillsboro Medical Center Interventional Radiology
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Uterine Fibroid Embolization – New Patient Form

1. Who is your primary care provider? _____
2. Who provides your gynecological care? _____
3. How old were you when you had your first period? _____ Date of your last period: _____
4. How many times have you:

   Been pregnant? _____ Had a baby? _____ Had a miscarriage? _____
5. Have you tried to get pregnant but were unable? ☐ Yes ☐ No
6. Do you plan to have children in the future? ☐ Yes ☐ No
7. When was your last pap smear? _____ Was it normal? ☐ Yes ☐ No
8. Have you ever had pelvic surgery (or C-Section)? ☐ Yes ☐ No
9. Have you ever had a pelvic infection? ☐ Yes ☐ No
10. Do you have abnormal bleeding? ☐ Yes ☐ No

If you answered yes:

a. How long has this been a problem? _____
b. How long do your periods last? _____
c. Do you have bleeding between periods? ☐ Yes ☐ No
d. Have you ever been told you were anemic? ☐ Yes ☐ No When? _____
e. Have you ever needed blood transfusions because of vaginal bleeding? ☐ Yes ☐ No
f. On a scale of 0-5, how much of a problem is your bleeding? Please circle.

(None) 0 1 2 3 4 5 (Severe)

11. Do you have pain? ☐ Yes ☐ No

If you answered yes:

a. How long has this been a problem? _____

b. When do you have pain? ☐ Only on your period ☐ During sex ☐ All the time

c. On a scale of 0-5, how bad is your pain? Please circle.

(None) 0 1 2 3 4 5 (Severe)

12. What other problems do you have? Please check all that apply.

Problem	**Yes**	**No**	**How bad is the problem? Circle.**
Urinating too often			0 1 2 3 4 5 (Severe)
Abdomen (stomach) feels full			0 1 2 3 4 5 (Severe)
Many bladder infections			0 1 2 3 4 5 (Severe)
Leg swelling or varicose veins			0 1 2 3 4 5 (Severe)
Trouble controlling bladder or bowels			0 1 2 3 4 5 (Severe)
Other: _____			0 1 2 3 4 5 (Severe)
Other: _____			0 1 2 3 4 5 (Severe)
Other: _____			0 1 2 3 4 5 (Severe)

13. Please answer the questions below about how uterine fibroid symptoms have affected your life.

In the past 3 months, how much did the following bother you?	**None**	**A little**	**Some**	**Much**	**Very much**
Heavy bleeding during your period					
Passing blood clots during your period					
Changing of how long your period lasts					
Changing of how long your monthly cycle is					
Feeling tightness or pressure in your pelvic area					
Needing to urinate often during the day					
Needing to urinate often at night					
Feeling tired or worn out					

In the past 3 months, how often did your symptoms …?	None	A little	Some	Much	Very much
Make you feeling anxious because you don't know when your periods will start or how long they last					
Make you feel anxious about traveling					
Interfere with your physical activities					
Cause you to feel tired or worn out					
Make you reduce the amount of time you exercise or do physical activity					
Make you feel like you are not in control of your life					
Make you worry that you would stain your underwear					
Make you feel less productive					
Cause you to feel sleepy during the day					
Make you feel self-conscious of weight gain					
Make you feel like it is hard to do your usual activities					
Interfere with your social life					
Make you feel self-conscious about the size of your stomach					
Make you worried about staining your bed sheets					
Make you feel sad or hopeless					
Make you feel down or blue					
Make you feel wiped out					
Cause you to be worried about your health					
Cause you to plan activities more carefully					
Make you feel annoyed that you have to always carry extra pads, tampons and clothes for accidents					
Make you feel embarrassed					
Make you feel uncertain about your future					
Make you feel irritable					
Make you worried about staining your outer clothes					
Make you change the size of the clothes you wear during your periods					
Make you feel like you are not in control of your health					
Make you feel weak, like your body has no energy body					
Lower your sex drive					
Cause you to avoid sex					

Patient Signature: _____ Date: _____

Patient Name: _____