HOUSTON FIBROIDS

UFE Intake Form

Name:_____ **Referring MD:**_____

Age:_____ **Cc:**_____

Date:_____

Fibroid Diagnosis:_____

Menstrual Cycle:

Length: _____ # Heavy Days:_____ ☐ Pads ☐ Tampons ☐ Both

Frequency of change:_____

LMP: _____ Onset of menses:_____

☐ clots ☐ flooding ☐ anemia ☐ blood transfusion ☐ iron transfusion

Hct: _____ __/__/__

Cramps	☐ prior to cycle	☐ during cycle	☐ after cycle	☐ daily
Pelvic Pain	☐ prior to cycle	☐ during cycle	☐ after cycle	☐ daily
Pelvic Pressure	☐ prior to cycle	☐ during cycle	☐ after cycle	☐ daily
Bloating	☐ prior to cycle	☐ during cycle	☐ after cycle	☐ daily
Urinary Sx	☐ prior to cycle	☐ during cycle	☐ after cycle	☐ daily
Other	☐ prior to cycle	☐ during cycle	☐ after cycle	☐ daily

Fibroid Therapies:

BCP's: _____ Progestins: _____ GnRh Agonists:_____

Myomectomies:_____ Lupron/Depo: __/__/__ ☐ 1m ☐ 3m

Last Pap: __/__/__ Normal: ☐ Y ☐ N Endometrial Biopsy: ☐ Y ☐ N

Pregnancies:_____ Miscarriages/Abortions:_____ Infertility:_____ Menopausal Sx: ____

PE:_____

Vitals:_____

Gen:_____

Respiratory:_____

CV:_____

Abd:_____

Ext Femoral ☐ R ☐ L

New Patient Office Visit

Past Medical History:	Allergies:
Past Surgical History:	Medications:
Family History:	Imaging:
Social History:	Recent Labs:
Psychosocial History:	Vital Signs: Height: Weight: Blood Pressure: Pulse: Respirations: Temperature: O_2 Sat:
Review of Systems:	

Current Symptoms

Check off any symptoms that you are currently experiencing.

GENERAL
- ☐ Fatigue
- ☐ Decreased Appetite
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Insomnia

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Bloody Stool
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea/vomiting

NEUROLOGIC
- ☐ Headaches
- ☐ Dizziness
- ☐ Difficulty walking
- ☐ Numbness

EYES
- ☐ Change in vision
- ☐ Pain
- ☐ Double vision

GENITOURINARY
- ☐ Change in bowel habits
- ☐ Painful urination
- ☐ Bloody urine
- ☐ Increased Urination
- ☐ Abnormal vaginal discharge
- ☐ Pregnant

PSYCHIATRIC
- ☐ Anxiety
- ☐ Irritability
- ☐ Sexual Problems
- ☐ Suicidal ideation
- ☐ Depression

EARS, NOSE, THROAT
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Sinus pain
- ☐ Sore throat

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Leg swelling
- ☐ Wounds on feet
- ☐ Skin color changes on legs

ENDOCRINE
- ☐ Frequent thirst
- ☐ Frequent urination
- ☐ Heat or cold intolerance

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ High blood pressure

BREASTS
- ☐ Lumps
- ☐ Pain
- ☐ Nipple discharge

HEMATOLOGIC
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ Easy bleeding

RESPIRATORY
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing

SKIN
- ☐ Mole changes
- ☐ Rashes

ALLERGIC/IMMUNOLOGIC
- ☐ Itching
- ☐ Chronic Infections

OTHER:_____

Reviewed: _____

Uterine Fibroid Symptom And Health-Related Quality Of Life Questionnaire (UFS-QOL)

Pt Initials:_____ Pt ID:_____ Date:_____

Listed below are symptoms experienced by women who have uterine fibroids. Please consider each symptom as it relates to your uterine fibroids or menstrual cycle. Each question asks how much distress you have experienced from each symptom during the previous 3 months.
There are no right or wrong answers. Please be sure to answer every question by checking the most appropriate box. If a question does not apply to you, please mark "not at all" as a response.

During the previous 3 months, how distressed were you by:	Not at all	A little bit	Somewhat	A great deal	A very great deal
Heavy bleeding during your menstrual period	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Passing blood clots during your menstrual period	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Fluctuation in the duration of your menstrual period compared to your previous cycle	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Fluctuation in the length of your monthly cycle compared to your previous cycles	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Feeling tightness or pressure in your pelvic area	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Frequent urination during the daytime hours	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Frequent nighttime urination	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Feeling fatigued	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

The following questions ask about your feelings and experiences regarding the impact of uterine fibroid symptoms on your life. Please consider each question as it relates to your experiences with uterine fibroids during the previous 3 months.
There are no right or wrong answers. Please be sure to answer every question by checking the most appropriate box. If the question does not apply to you, please check "none of the time" as your option.

During the previous 3 months, how often have your symptoms related to uterine fibroids:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Made you feel anxious about the unpredictable onset or duration of your periods?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you anxious about traveling?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Interfered with your physical activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Cause you to feel worn out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you decrease the amount of time you spent on exercise or other physical activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel as if you are not in control of your life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you concerned about soiling underclothes?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

During the previous 3 months, how often have your symptoms related to uterine fibroids:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Made you feel less productive?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Caused you to feel drowsy or sleepy during the day?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel self-conscious of weight gain?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel that it was difficult to carry out your usual activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Interfered with your social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel self-conscious about the size and appearance of your stomach?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you concerned about soiling bed linen?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel sad, discouraged, or hopeless?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel down-hearted and blue?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel wiped out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Caused you to be concerned or worried about your health?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Caused you to plan activities more carefully?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel inconvenienced about always carrying extra pads, tampons, and clothing to avoid accidents?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Caused you embarrassment?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel uncertain about your future?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel irritable?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you concerned about soiling outer clothes?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Affected the size of clothing you wear during your periods?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel that you are not in control of your health?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Made you feel weak as if energy was drained from your body?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Diminished your sexual desire?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Caused you to avoid sexual relations?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5