Desert Endovascular Center

Patient Name: _____

Name you prefer to be called: _____

Preference for contact: Phone ☐ Email ☐

Best contact phone number: _____

Email address: _____

OPTIONAL:

For continuation of care, please provide the names of your medical care providers below if you would like us to send them our notes from today's visit:

Name of Primary Care Physician: _____

Name of any other Physicians you want to receive your records (ie: oncologist, cardiologist, gynecologist, etc):

_____

UTERINE ARTERY/FIBROID EMBOLIZATION CONSULT

Do you have vaginal bleeding: yes no

How would you rate the bleeding: mild moderate severe

Do you have bleeding between periods: yes no

Do you have pain: yes no severity of pain 1-10 (10 being the worst _____

Do you have any urinary symptoms: yes no (frequency or incontinence)

Do you have adenomyosis: yes no

Have you had prior fibroid treatment: yes no what type_____

Date of last menstrual cycle: _____

Number of pregnancies: _____

Number of live born children: _____

Prior Surgery? Type? Date?

_____

_____

_____

_____

_____

_____

_____

Current medications being taken? Dose? Frequency?

_____

_____

_____

_____

_____

Allergic to any medication? _____

Allergic to latex? _____

Do you have cancer? _____

Do you have depression? _____

Do you have asthma, emphysema, or shortness of breath? _____

Do you have high blood pressure, chest pain, heart disease or have you had a heart attack? _____

Do you have hepatitis or liver disease? _____

Do you have diabetes, easy bleeding or bruising, anemia, or low blood count? _____

Do you have kidney disease or failure? _____

Do you have menopausal symptoms? _____

Social History:

Please circle: Single Married Divorced Widowed

Did you bring anyone with you today? If so, who? _____

Smoke: Yes or No? If yes, how much per day? _____

Previously smoked: Yes or No? If yes, when did you quit? _____

Consume alcohol: Yes or No? If yes, how much per week? _____

Does anyone else in the family have a history of the same condition that you are seeing the doctor for today? Yes or No? If yes, who? _____