Desert Endovascular Center- New Patient Packet

Patient Information

Patient Name: _____
Name you prefer to be called: _____
Preference for contact: ☐ Phone ☐ Email
Best contact phone number: _____
Email address: _____

OPTIONAL: Medical Care Provider Information

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

Primary Care Physician: _____

Other Physicians to receive records (e.g., oncologist, cardiologist, gynecologist, etc.):

Uterine Artery/Fibroid Embolization Consult

Do you have vaginal bleeding? ☐ Yes ☐ No
If yes, how would you rate the bleeding? ☐ Mild ☐ Moderate ☐ Severe
Do you have bleeding between periods? ☐ Yes ☐ No
Do you have pain? ☐ Yes ☐ No
If yes, severity of pain (1-10, 10 being worst): _____

Do you have any urinary symptoms? ☐ Yes ☐ No (e.g., frequency, incontinence)
Do you have adenomyosis? ☐ Yes ☐ No
Have you had prior fibroid treatment? ☐ Yes ☐ No
If yes, what type: _____
Date of last menstrual cycle: _____

Number of pregnancies: _____
Number of live-born children: _____

Surgical History

Prior surgeries? ☐ Yes ☐ No
If yes, type and date: _____

Current Medications

Medication: _____
Dose: _____
Frequency: _____

Allergies

Allergic to any medication? _____
Allergic to latex? _____

Medical History

- **Cancer:** ☐ Yes ☐ No
- **Depression:** ☐ Yes ☐ No
- **Asthma, emphysema, or shortness of breath:** ☐ Yes ☐ No
- **High blood pressure, chest pain, heart disease, heart attack:** ☐ Yes ☐ No
- **Hepatitis or liver disease:** ☐ Yes ☐ No
- **Diabetes, easy bleeding/bruising, anemia, or low blood count:** ☐ Yes ☐ No
- **Kidney disease or failure:** ☐ Yes ☐ No
- **Menopausal symptoms:** ☐ Yes ☐ No

Social History

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Did you bring anyone with you today? If yes, who? _____
Do you smoke? ☐ Yes ☐ No
If yes, how much per day? _____
Previously smoked? ☐ Yes ☐ No
If yes, when did you quit? _____
Do you consume alcohol? ☐ Yes ☐ No
If yes, how much per week? _____

Family history of same condition you are being seen for today? ☐ Yes ☐ No
If yes, who? _____