Desert Endovascular Center

Uterine Fibroid – New Patient Packet

Patient Information

Patient Name: _____
Preferred Name: _____

Preferred Contact Method: ☐ Phone ☐ Email
Best Contact Phone Number: _____
Email Address: _____

Optional – Continuation of Care

If you would like us to share notes from today's visit, please provide the names of your medical care providers:

- **Primary Care Physician:** _____
- **Other Physicians (e.g., 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 worst):** ____
- **Do you have any urinary symptoms (frequency or incontinence)?** ☐ Yes ☐ No
- **Do you have adenomyosis?** ☐ Yes ☐ No
- **Have you had prior fibroid treatment?** ☐ Yes ☐ No
    - **Type:** _____
- **Date of last menstrual cycle:** _____
- **Number of pregnancies:** ____
- **Number of live-born children:** ____

Medical & Surgical History

- **Prior Surgery (Type & Date):** _____
- **Current Medications (Dose & Frequency):** _____
- **Allergies to Medications:** _____
- **Allergic to Latex?** ☐ Yes ☐ No
- **Do you have cancer?** ☐ Yes ☐ No
- **Do you have depression?** ☐ Yes ☐ No
- **Do you have asthma, emphysema, or shortness of breath?** ☐ Yes ☐ No
- **Do you have high blood pressure, chest pain, heart disease, or history of heart attack?** ☐ Yes ☐ No
- **Do you have hepatitis or liver disease?** ☐ Yes ☐ No
- **Do you have diabetes, easy bleeding/bruising, anemia, or low blood count?** ☐ Yes ☐ No
- **Do you have kidney disease or failure?** ☐ Yes ☐ No
- **Do you have menopausal symptoms?** ☐ Yes ☐ No

Social History

- **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
- **Did you bring anyone with you today?** _____
- **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 the same condition you are being seen for today?** ☐ Yes ☐ No
    - **If yes, who?** _____