WAKE RADIOLOGY
DIAGNOSTIC IMAGING, INC.
INTERVENTIONAL SERVICES

H&P Questionnaire for UAE Evaluation

Patient Name: _____

Date of Birth: _____

What problems caused by your fibroids are bothering you the most?

_____

_____

When and how did you first know that you had fibroids? _____

_____

Have you had any treatment, (medications or procedures) **for this problem? YES NO**

If yes, please explain:_____

If the problem is bleeding, how many pads / tampons do you use per day?_____

Have you been told that you are anemic (low blood count)? YES NO

Have you had a transfusion for your anemia? YES NO If yes, when? _____

If you have pain, please describe the location of the pain and when the pain occurs?

_____

On a scale of 1-10, list your pain severity: _____

Do you take medication for the pain, prescribed or over-the-counter? YES NO

Please indicate medication, dosage and how often taken: _____

Do you get up in the middle of the night to urinate? YES NO If yes, how often? _____

Is sexual intercourse painful to you? YES NO

Pregnancy History:
Number of pregnancies: _____ Number of live births: _____ History of infertility? YES NO