How did you hear about us?

- Social media
- Friend
- Web search
- Hospital
- Physician or medical professional

Patient Intake Form for Uterine Fibroids:

Patient Information

- Name: _____
- Date of Birth: _____
- Contact Number: _____
- Email: _____

Surgical History

1. Have you had any previous abdominal or bowel surgeries? (yes/no)

If yes, please specify procedure name, date, surgeon, and facility performed at:

_____

_____

Menstrual Cycle

1. Age at first menstrual cycle: _____
2. Cycle Length (days between cycles): _____
3. Do your menstrual cycles occur monthly? (yes/no) If No, please specify:

_____

_____

4. Do you bleed in between your menstrual cycles? (yes/no)
5. Duration of Menstrual Bleeding (days bleeding): _____
6. Are your cycles heavy? (yes/no)
   How often do you change pads/tampons?: _____
7. Are your menstrual cycles painful? (yes/no)
8. Have you missed work or school due to your menstrual cycle? (yes/no)

If your Menstrual Cycles are Heavy, please check all that apply:

- [ ] Clots in menstrual flow: Do you pass clots larger than a quarter size? (yes/no)
- [ ] Bleeding between periods
- [ ] Anemia symptoms (fatigue, dizziness)

- [ ] Need for blood or iron infusions (please specify): _____
- [ ] Other bleeding concerns (please specify): _____

Bulk Symptoms (Please check all that apply)
- [ ] Abdominal fullness or pressure
- [ ] Difficulty emptying bladder
- [ ] Urinary frequency
- [ ] Constipation/Bloating
- [ ] Pain during intercourse
- [ ] Back pain
- [ ] Other symptoms (please specify): _____

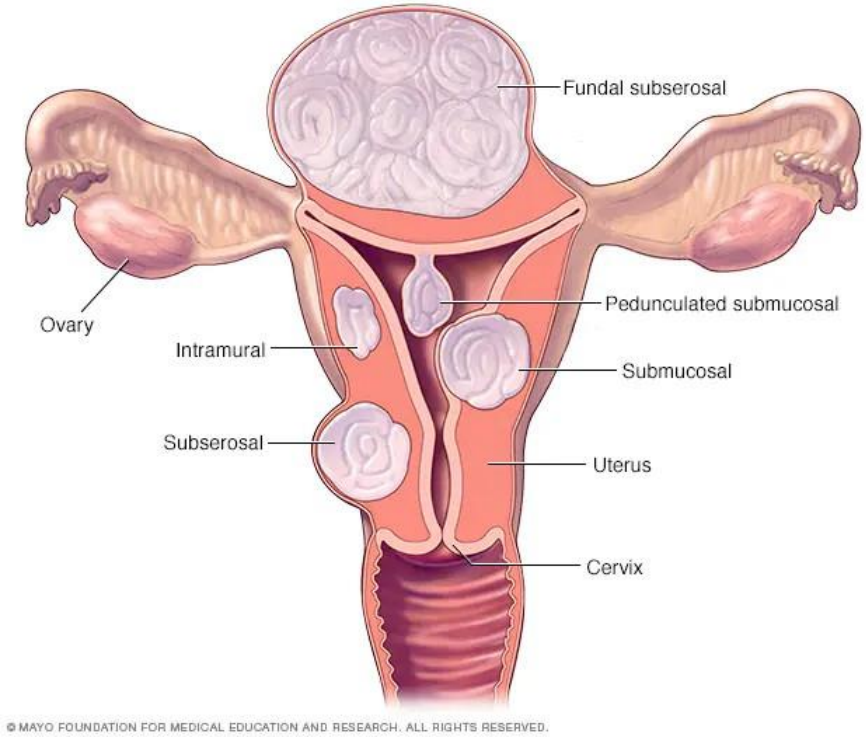
Pregnancy History
1. Number of pregnancies: _____
2. Number of live births: _____
3. Number of miscarriages: _____
4. Any history of pregnancy complications? (Yes/No) If yes, please specify:
_____
5. Future pregnancy desires: _____

Infertility
1. History of infertility treatments? (Yes/No) If yes, please specify treatment(s) and number of cycles:
-Medications: _____
-IVF: _____
-Other: _____
2. Cause of Infertility (please specify): _____

Imaging Studies
1. Have you had any imaging done related to uterine fibroids? (e.g., ultrasound, MRI) (yes/no) If yes, please provide details:
  - Type: _____
  - Date: _____
  - Results: _____

Prior Treatments
1. Have you received any treatments for uterine fibroids? (yes/no) If yes, please specify:
  - Medications: _____
  - Surgical interventions: _____
  - Other treatments: _____
(Pelvic floor physical therapy, Acupuncture, Diets)

Uterine Diagrams:



Additional Comments or Concerns:

_____

_____

_____

_____

Patient Signature:_____ Date: _____

Please complete and bring this with you to your fibroid consultation appointment.