

**Please complete this form and bring to your
consultation. Thank you!**

RADIOLOGY ASSOCIATES OF
DEKALB

**UTERINE
FIBROID
EMBOLIZATION:
RELIEF FROM YOUR
FIBROIDS WITHOUT
SURGERY**

Name:

Telephone: (please check preferred contact)

- Home:
- Work:
- Cell:
- Email Address:

Home Address:

Current Medical Provider:

Name of doctor:

Phone Number:

Insurance:

Policy Holder Name:

Policy Holder Birthdate:

Policy Holder Address:

Policy Holder Employer:

Fibroid History:

When were your uterine fibroids first diagnosed?

Do you have bleeding between periods? Yes No

Please check all symptoms you experience.

- Heavy menstrual cycle
- Pelvic pain/Cramping
- Constipation
- Frequent urination
- Bloating

My normal menstrual cycle lasts _____ days and occurs every _____ days.

During my menstrual cycle I typically use _____ pads/tampons every _____ hours.

Previous Fibroid Treatment:

- NSAIDS (Ibuprofen, Naproxen)
- Hormonal (Lupron)
- Myomectomy
- Other

Do you desire to have children in the future? Yes No

Name:

Family History:

- Stroke
- Heart disease
- Cancer
- Bleeding disorder/Anemia
- Fibroids
- Blood clots/Pulmonary Embolism

Social History:

Tobacco (packs/day)

Alcohol (drinks/week)

Review of Systems / Medical History — please check all that apply

- | | |
|---|--|
| <input type="radio"/> Abnormal Bleeding | <input type="radio"/> Hernia |
| <input type="radio"/> Allergies | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Anemia | <input type="radio"/> High Cholesterol |
| <input type="radio"/> Anxiety | <input type="radio"/> Headaches / Migraines |
| <input type="radio"/> Arthritis | <input type="radio"/> Heart Problems |
| <input type="radio"/> Asthma | <input type="radio"/> Intestinal / Stomach Trouble |
| <input type="radio"/> Cancer(type) | <input type="radio"/> Low Back Condition / Scoliosis |
| <input type="radio"/> Chest Pain | <input type="radio"/> Neurological Disorder |
| <input type="radio"/> Chronic Cough | <input type="radio"/> Seizure Disorder |
| <input type="radio"/> Depression | <input type="radio"/> Sickle Cell Trait |
| <input type="radio"/> Diabetes | <input type="radio"/> Sinus Problems |
| <input type="radio"/> Ear Trouble / Hard of Hearing | <input type="radio"/> Skin Disease |
| <input type="radio"/> Eating Disorder | <input type="radio"/> Syncope / Fainting |
| <input type="radio"/> Eye Trouble/Vision Loss | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Gallbladder Disease | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Hepatitis | |

Drug Allergies:

Sensitivity/Latex Allergy/Food or Environmental Allergy None Penicillin, Ampicillin

Latex allergy

Other _____

How did you hear about Uterine Fibroid Embolization?

- My Doctor
- Friend (Who may we thank for this referral?)
- Internet
- Radio Ad
- Print Ad

If you have any questions before your consultation please contact Krystal Stokes, UFE patient coordinator, at 404-564-5404 ext 14 or visit us at our website radadpc.com.