Fibroid Center at Cooperman Barnabas Medical Center

Once completed, please fax to 973-322-8064 or email Veronica.Roldan@rwjbh.org

Full Name (Last, First, MI)_____ Date of Birth_____

Address (street, town, state)_____

Phone Numbers Home_____ Work_____ Cell_____

Email_____ Primary Insurance_____

1. When were you first diagnosed with fibroids? _____

2. What symptoms are you having? Circle all that apply.
   - a. Heavy menstrual bleeding
   - b. Painful periods
   - c. Bleeding between periods
   - d. Pelvic pressure or heaviness
   - e. Pressure on bladder -frequent urination or urination at night
   - f. Pain with intercourse
   - g. Pressure on bowels with constipation
   - h. Abdominal bloating
   - i. Back or leg pain

3. If you have heavy bleeding, how often you do change your pad/tampon?
   a. Once an hour or less b. Every 1-2 hours c. Every 2 or more hours

4. If you have heavy bleeding, do you pass clots larger than the size of quarters? Yes No

5. If you have heavy bleeding, have you been diagnosed with anemia? Yes No

6. How many days do you bleed when you have your periods?_____

7. How many days from the beginning of one period to the beginning of the next period?_____

8. What evaluation of your fibroids have you had in the past? Circle all that apply.
   - a. Ultrasound
   - b. MRI
   - c. Biopsy of uterine lining (endometrial biopsy)
   - d. D&C
   - e. none

9. What treatments have you previously had for your fibroids? Circle all that apply.
   - a. Medical therapy (birth control pills or injections, IUD, Lupron© injection, projestins, tranexamic acid)
   - b. Hysteroscopic resection (removal of fibroid through vagina)
   - c. Myomectomy (abdominal or laparoscopic removal of fibroids, leaving uterus in place)
   - d. Uterine fibroid embolization
   - e. MR-guided focused ultrasound (also known as HI-FU, ExAblate©)

10. Do you desire to maintain your fertility? Yes No

11. Have you had previous abdominal surgery for conditions other than fibroids? Yes, please list No

_____

12. Do you have any other medical problems? Yes No
    Circle all that apply; if you say yes to any, please explain.
    - a. Heart disease _____
    - b. Lung disease (including asthma) _____
    - c. Kidney (or Renal) disease_____
    - d. Diabetes_____
    - e. High blood pressure_____
    - f. Other _____

13. What medications are you taking? Please list_____

14. Do you have any food allergies? Yes No If so, please explain_____
    Are you allergic to any medications? Yes No If so, please explain_____
    Have you ever had an allergic reaction to contrast dye used during any radiologic study?
    Yes No If so, please explain _____

15. Who is your primary gynecologist? Physician's Name_____

Physician's Address_____

Physician's Phone _____

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