Name_____ DOB_____

Fibroid / Adenomyosis Questionnaire

Who referred you to our practice? _____

OR

How did you hear about our practice? _____

Name of your gynecologist_____

When were you diagnosed with uterine fibroid and/or adenomyosis? _____

Does anyone in your family have fibroids? _____

Do you have

- Heavy menstrual bleeding? ◯Yes ◯No
- Pelvic / abdominal pain? ◯Yes ◯No
- Back pain? ◯Yes ◯No
- Frequent urination? ◯Yes ◯No
- Constipation? ◯Yes ◯No
- Painful intercourse? ◯Yes ◯No
- Anemia ◯Yes ◯No

Menstrual history

- Last menstrual period date _____
- Bleeding is ◯regular ◯irregular
- Passing clots ◯Yes ◯No
- Gushing ◯Yes ◯No
- Using ◯tampons ◯feminine pads ◯both
- Number of days bleeding during menses _____
- Number of days of **heavy** bleeding during menses _____
- During heaviest bleeding how often do you change pad/tampon? Every _____ hour(s).

Last Pap smear date: _____ Result was ◯normal ◯abnormal

Endometrial biopsy date: _____ Result was ◯normal ◯abnormal ◯No biopsy done

Pelvic ultrasound date:_____ Facility? _____

Do you have children? ◯Yes ◯No How many? _____

Do you desire future pregnancy? ◯Yes ◯No

What other treatment have you tried for your symptoms?_____

Did you discuss fibroid/adenomyosis treatment with your gynecologist? ◯Yes ◯No

Have symptoms of uterine fibroids/adenomyosis affected quality of your life? ◯Yes ◯No