UNIVERSITY of VIRGINIA HEALTH SYSTEM

UVA Radiology Vein and Vascular Care

UFE Screening Form

NAME: ____________________ AGE: ____________
REASON FOR VISIT: ____________________
REFERRING MD: ____________________ OB/GYN: ____________________

HISTORY OF PRESENT ILLNESS:

1. Check all symptoms related to fibroids that you currently have:
   ____ Heavy bleeding ____ Bleeding between periods ____ Clotting
   ____ Constipation ____ Urinary Frequency ____ Back Pain
   ____ Leg Pain ____ Pelvic pain/pressure ____ Abdominal pain
   ____ Abdominal bloating ____ Pain during intercourse ____ Abdominal distention
2. How many days long is your typical period? ____________
3. If you have heavy bleeding, how many pads/tampons do you use in 24 hour period? ____________
4. If you experience constipation, how long has it been a problem? ____________
5. How long have you experienced fibroids? ____________
6. Describe any other fibroid symptoms you have: ____________

GYNECOLOGICAL HISTORY:

1. How many times have you been pregnant? ____________
2. Do you hope to have a future pregnancy? ____________
3. Date of last Pap smear? ____________
4. History of abnormal Pap Smears? ____________ If so, when and results? ____________
5. Do you have a history of anemia? ____________
6. If yes to anemia, have you ever had a blood transfusion? ________ If transfused, when? ____________
7. Have you used iron supplements? ____________
8. Have you ever had endometrial biopsy? ____________
   If yes, when did you have it and what were the results?____________
9. Have you had hormone treatment for fibroids? ____________ Date of last treatment? ____________
   If yes, which one? _____ Birth control _____ Depo-Provera _____ Estrogen/Progestin _____ Lupron ____
10. Do you have vaginal discharge other than bleeding? ____________ Does it have odor? ____________
11. Any history of pelvic infection (PID or STD)? ____________ If yes, when? ____________
12. Have you ever had fibroids surgically removed? ____________
13. Please list any other surgeries involving the uterus and ovaries you have had:
    ____
14. Check any symptoms you may have related to menopause:
    _____ Hot flashes _____ Cold hands/feet _____ Night sweats _____ Headaches
    _____ Dizziness _____ Weight gain _____ Fatigue _____ Irritability
    _____ Nervousness _____ Insomnia _____ Difficulty concentrating
15. List any sexual concerns that may be related to fibroids:
    ____

RECENT IMAGING:

Ultrasound: ____________________ MRI: ____________________
When and where: ____________________