Dr Gary Sudwarts
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Official Use
Blood test results: U..... C .....GFR.... Platelets ..... WCC ..... HB ..... INR .....

GYNAECOLOGICAL PATIENT HISTORY QUESTIONNAIRE

UTERINE FIBROID EMBOLISATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. By completing this form in advance, it will allow us to understand your problem and plan the appropriate treatment.

Name *(First, Last):*	**DOB:**	Age:
Name of current gynaecologist:	**Hospital at which your gynaecologistr consults:**	

PERSONAL CONTACT DETAILS

Home address:			
Country:		**ID/Passport number:**	
Occupation:		**Employer:**	
Contact Numbers:	Home:	Cellular:	
	Work:	Email:	
Medical Aid Company		**Medical Aid Membership No.:**	

PLEASE INCLUDE A COPY OF YOUR IDENTITY DOCUMENT OR PASSPORT AS WELL AS A COPY OF YOUR MEDICAL AID CARD WITH THE SUBMISSION OF THIS FORM

MENSTRUAL AND GYNAECOLOGICAL HISTORY

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Current Symptoms or Illness that brought you to contact us:

What are your major fibroid related problems?

☐	Heavy menstrual bleeding	☐	Tiredness	☐	Pelvic Pain
☐	Large Abdominal mass	☐	Bowel pressure with constipation and bloating	☐	Dizziness
☐	Bulk related pressure	☐	Back and leg pain	☐	Pain during intercourse
☐	Bladder pressure with frequent urination	☐	Other		

Please elaborate on other problems:

How many days does your period last each month:

Approximately how many days between each period:

Please describe your period:

☐ Regular	☐ Irregular	☐ None
☐ Bleeding between periods/Spotting	☐ Light	☐ Heavy

How painful are your periods?

☐ None	☐ Mild	☐ Moderate	☐ Severe
What medication do you use for the pain?			
Do you spot or bleed between periods or after intercourse?		☐ Yes	☐ No
Have you ever required iron supplements for anaemia?		☐ Yes	☐ No
Have you ever had a blood transfusion?		☐ Yes	☐ No

Number of pregnancies:				Number of living children:			
Premature:		Miscarriages:		Ectopic:		Termination of pregnancy:	
Caesarean birth or natural:							
Please describe any pregnancy complications you may have had:							
Do you still wish to have children?		☐ Yes		☐ No			
What is your present method of birth control?							
Do you currently use an intra-uterine contraceptive device?	☐ Yes	☐ No		If yes, please provide details of IUD			
Do you currently have any vaginal discharge or irritation?		☐ Yes		☐ No			
Do you have difficulty with sexual intercourse?	☐ Yes	☐ No		Do you experience pelvic pain or discomfort?	☐ Yes	☐ No	
Date of last Pap Smear?							
Have you ever had an abnormal Pap Smear?		☐ Yes		☐ No			
Have you had fertility problems?		☐ Yes		☐ No			
If yes, please describe (IVF, endometriosis, etc):							

FAMILY HEALTH HISTORY

Do your parents or siblings have any of the following? (Check all that apply)			
☐ Breast cancer	☐ Uterus cancer	☐ Ovary Cancer	☐ Bowel Cancer
☐ High Cholesterol	☐ Stroke	☐ Blood clots	☐ Diabetes
☐ Liver Cancer	☐ Heart Disease	☐ High Blood Pressure	☐ Other
If other, please describe:			

MEDICAL HISTORY

Do you have any medical problems? Please check all that apply				
☐ Asthma	☐ Diabetes	☐ Heart Disease	☐ Seizure disorder	☐ Clotting disorder
☐ Pulmonary Embolus	☐ Migraine Headaches	☐ Abnormal Cholesterol	☐ High Blood Pressure	☐ Gall Bladder Disease
☐ Thyroid Problems	☐ Urinary Tract Problem	☐ Hormonal/ Endocrine	☐ Deep Vein Thrombosis (DVT)	☐ Other
If other, please describe:				

HIV Status		
Are you HIV positive?	☐ Yes	☐ No

If yes, what was your latest CD4 Count?		Date:	
Are you on Anti-Retro Viral (ARVs) medication?		☐ Yes	☐ No
Allergies to medications			
Are you allergic to any medicine?		☐ Yes	☐ No
Name of Drug		Reaction you had	
Have you ever had an allergic reaction to iodine based contrast media (e.g allergic reaction during a CT scan)?		☐ Yes	☐ No

SURGICAL HISTORY

Surgeries		
Date	Reason	Hospital
Other hospitalizations/operations		
Date	Reason	Hospital

Have you had a myomectomy		☐ Yes		☐ No	
Date:		Open/Laproscopic:		Where:	
Date:		Open/Laproscopic:		Where:	
Have you had a Uterine Fibroid Embolisation (UFE)?		☐ Yes		☐ No	
If yes, please provide details:					
Have you ever had vascular surgery or problems with the veins or arteries in your legs?		☐ Yes		☐ No	
If yes, please describe:					

MEDICINES, NUTRITIONAL SUPPLEMENTS AND VITAMINS

List your prescribed drugs and over-the-counter drugs, such as vitamins, nutritional supplements and inhalers		
Name of drug/vitamin/nutritional supplement	Strength	Frequency taken

Are you currently taking warfarin, asprin or any other blood thinning medication?	☐ Yes	☐ No
If yes, please supply the name and dosage:		

EXPECTATIONS AND QUESTIONS

How did you hear about UFE and Dr Sudwarts					
☐ A friend/colleague	☐ A doctor	☐ Read an article	☐ The internet	☐ TV	☐ Radio
What are your expectations from your visit and what questions do you want answered?					

When would you like your UFE to take place?	

Disclaimer:

I, _____, confirm that all the information supplied above is true. Should any details change between the time of submission of this form and having the Uterine Fibroid Embolisation done, I will inform Dr Sudwarts of those changes.

Date: _____

Official use:					
Name of Patient:					
Date of Assessment:					
Tests performed:					
MRI	☐	Ultrasound	☐	Blood tests INR, Full blood count U&E	☐
UFE indicated:		☐ Yes		☐ No	