THE MICROSURGERY

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.

FULL NAME:		**Weight (kg):**	**Height (m):**
Previous or referring Doctor/gynaecologist:		**Date of birth:**	
Contact number of referring Doctor/gynaecologist:		**Date of last physical exam:**	
PERSONAL CONTACT DETAILS			
Home address:			
Country:		**ID/Passport number:**	
Occupation:		**Employer:**	
Contact info:	Home:	Cell:	
	Work:	Email:	
Medical Aid Company and Policy details:		**Medical Aid Membership no.**	
Main member Name & ID			
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			
Have you ever been diagnosed with:			
☐ Fibroids		☐ Adenomyosis	
☐ Endometriosis		☐ Uterine/ovarian or cervical cancer	
How many days does your period last each month:		Approximately how many days between each period:	
Please describe your period:			
☐ Regular	☐ Irregular	☐ None	☐ Passing clots
☐ 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 after intercourse?		☐ Yes	☐ No
Have you ever required iron supplements for anaemia?		☐ Yes	☐ No

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If yes, please state which supplements you use(d):							
Have you ever had a blood transfusion?					☐ Yes	☐ No	
Number of pregnancies:				Number of living children:			
Premature:		Miscarriages:		Ectopic:		Termination of pregnancy:	
Please describe any pregnancy complications you may have had:							
Do you still wish to have children?			☐ Yes		☐ No		
Are you currently in a sexual relationship?			☐ Yes		☐ No		
What is your present method of birth-control?							
☐ Oral contraceptive		☐ Condom			☐ Injection		
☐ Implant		☐ IUD			☐ Mirena		
If you use a an intra-uterine device, how long has it been in place?							
Do you currently have any vaginal discharge or irritation?					☐ Yes	☐ No	
Do you currently 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		
If yes, please state abnormality (Infection. Abnormal cells, cancer cells, etc.)							
Have you had fertility problems?			☐ Yes		☐ No		
If yes, please describe (IVF, endometriosis, etc.)							

FAMILY HEALTH HISTORY

Do your parents have any of the following? (Check all that apply)			
☐ Breast cancer	☐ Uterus cancer	☐ Ovary cancer	☐ Bowel cancer
☐ High cholesterol	☐ Stroke	☐ Pulmonary embolus/DVT	☐ Diabetes
☐ Liver cancer	☐ Heart disease	☐ High blood pressure	☐ Other
If other, please describe:			

MEDICAL HISTORY

Do you have any medical problems? (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:				

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HIV Status			
Are you HIV positive?		☐ Yes	☐ No
If yes, what was you 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 hospitalisations/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/arteries in your legs?			☐ Yes		☐ No
If yes, please describe:					

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MEDICINES. NUTRITIONAL SUPPLEMENTS AND VITAMINS			
List your prescribes 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 the 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?					
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:					
When would you like your UFE to take place?					

CONFIDENTIALITY
Information relating to your health status, treatment or visit to this practice is regarded as highly confidential. The doctors and staff employed at our practice will share information only with your involved specialist(s) and those persons who are assisting you with medical aid authorization and payment of medical aid claims. We will keep all your information confidential.
MEDICAL SCHEME: To motivate specific treatments to your medical scheme we must provide them with information on your health history and other health information. To submit an account to a medical scheme, we must provide, in terms of the law, codes on the account that discloses information to the scheme about your health condition. Your signature on this form indicates that you **consent** and **agree to this**. If you do not agree, please inform the practice without delay. In such cases, you or the person responsible for the account will have to pay the practice in full and claim from the medical scheme yourself.
COMMUNICATION: We also need your consent to communicate with you. Please complete the following:
Disclaimer:

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

Signature: _____ Date: _____

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