Alate Health

1213 HERMANN DRIVE, SUITE 255, HOUSTON, TX 77004

P 713.955.1707 **F** 713.955.1699 **W** ALATEHEALTH.COM

INITIAL FIBROID CONSULTATION QUESTIONNAIRE

PATIENT'S NAME	DATE

NAME OF DOCTOR WHO PERFORMS YOUR GYNECOLOGICAL EXAMS ◯ OB/GYN ◯ FAMILY PRACTICE		
ADDRESS		
CITY	STATE	ZIP
PHONE	DOB	

MENSTRUAL HISTORY

1. HOW OLD WERE YOU WHEN YOU FIRST GOT YOUR PERIOD?

2. WHEN WAS YOUR LAST MENSTRUAL PERIOD?

3. DO YOUR PERIODS COME AROUND THE SAME TIME EVERY MONTH? ◯ YES ◯ NO

4. HOW LONG DO THEY LAST?

5. DO YOU HAVE BLEEDING BETWEEN YOUR PERIODS? ◯ YES ◯ NO

6. DO YOU HAVE HEAVY BLEEDING DURING YOUR PERIODS? ◯ YES ◯ NO

A. IF SO, PLEASE RATE ON A SCALE OF 0-5 (WITH 5 BEING THE WORST):

7. DO YOU HAVE TO WEAR BOTH PADS AND TAMPONS? ◯ YES ◯ NO

8. HOW OFTEN ARE YOU CHANGING YOUR PADS/TAMPONS DURING YOUR HEAVIEST DAY?

9. ARE YOU PASSING BLOOD CLOTS DURING YOUR PERIODS? ◯ YES ◯ NO

A. IF SO, ARE THEY: QUARTER SIZE, HALF DOLLAR SIZE, FIST SIZE

10. DO YOU HAVE EXCESSIVE CRAMPING/PAIN WITH YOUR PERIODS? ◯ YES ◯ NO

A. IF SO, PLEASE RATE ON A SCALE OF 0-5 (WITH 5 BEING THE WORST):

11. HAVE YOU BEEN DIAGNOSED WITH ANEMIA? ◯ YES ◯ NO

12. DO YOU FEEL FATIGUED ALL THE TIME? ◯ YES ◯ NO

A. IF SO, PLEASE RATE ON A SCALE OF 0-5 (WITH 5 BEING THE WORST):

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BULK SYMPTOMS

13. DO YOU FEEL BLOATED DURING YOUR PERIODS OR IS YOUR ABDOMEN DISTENDED? ◯ YES ◯ NO

A. IF SO, PLEASE RATE ON A SCALE OF 0-5 (WITH 5 BEING THE WORST):

14. DO YOU FEEL TIGHTNESS OR PRESSURE IN YOUR PELVIC AREA EVEN WHEN YOU ARE OFF YOUR PERIODS? ◯ YES ◯ NO

A. IF SO, PLEASE RATE ON A SCALE OF 0-5 (WITH 5 BEING THE WORST):

15. DO YOU HAVE PAIN OR BLEEDING WITH INTERCOURSE? ◯ YES ◯ NO

A. IF SO, PLEASE RATE ON A SCALE OF 0-5 (WITH 5 BEING THE WORST):

16. DO YOU HAVE TO URINATE EXCESSIVELY? ◯ YES ◯ NO

A. IF SO, PLEASE RATE ON A SCALE OF 0-5 (WITH 5 BEING THE WORST):

GYN HISTORY

17. HAVE YOU BEEN DIAGNOSED WITH UTERINE FIBROIDS BY A MEDICAL PROFESSIONAL? ◯ YES ◯ NO

A. IF SO, WHEN?

19. HAVE YOU BEEN TREATED FOR FIBROIDS IN THE PAST? ◯ YES (SELECT WHICH TREATMENT BELOW) ◯ NO

A. BIRTH CONTROL PILLS

B. IUD

C. HORMONE INJECTIONS

D. MYOMECTOMY

E. ABLATION

20. WHEN WAS YOUR LAST ROUTINE GYNECOLOGICAL EXAM?

21. WHEN WAS YOUR LAST PAP SMEAR? WHERE WAS IT PERFORMED? WAS IT NORMAL?

22. HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? ◯ YES ◯ NO

A. IF SO, WHEN? WHAT WAS THE RESULT?

23. HAVE YOU EVER HAD AN ENDOMETRIAL BIOPSY? ◯ YES ◯ NO

A. IF SO, WHEN? WHAT WAS THE RESULT?

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OB HISTORY

24.	HOW MANY TIMES HAVE YOU BEEN PREGNANT?	
25.	HOW MANY CHILDREN DO YOU HAVE?	
26.	HAVE YOU EVER HAD PROBLEMS WITH INFERTILITY?	◯ YES ◯ NO
27.	DO YOU PLAN TO BECOME PREGNANT IN THE FUTURE?	◯ YES ◯ NO

IMAGING HISTORY

28.	DID THEY DIAGNOSE YOU USING:		
	A.	PALPATION	
	B.	ULTRASOUND	
	C.	CT SCAN	
	D.	MRI	
29.	ARE YOU CLAUSTROPHOBIC?		◯ YES ◯ NO
30.	DO YOU HAVE ANY METAL IN YOUR BODY?		◯ YES ◯ NO
	A.	IF SO, WHAT IS IT AND HOW LONG HAS IT BEEN THERE?	

HOW DID YOU FIRST HEAR ABOUT US?

◯ WEBSITE ◯ PHYSICIAN

◯ RADIO ◯ INSURANCE LIST

◯ TV ◯ EVENT

◯ FRIEND ◯ OTHER: