

Fibroid Questionnaire

Please complete this form and email, fax or post to the rooms prior to your consultation.

PATIENT PROFILE

Name:DOB:

What best describes your reason for attending?

- I have been diagnosed with fibroids, and am investigating treatment options
- I am seeking a second opinion
- I have symptoms of fibroids, but have not been diagnosed

When were you first diagnosed with fibroids?

Is there a family history of fibroids? If yes, please explain

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SYMPTOMS

Tell us about your symptoms. Please tick the symptoms you experience:

- | | |
|---|---|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Menorrhagia (heavy bleeding) | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Period pain |
| <input type="checkbox"/> Diarrhoea or constipation | <input type="checkbox"/> Pain with intercourse |
| <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Disruption to daily activities |
| <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Other, please specify: |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> I have no symptoms |

PERIODS

How often do your periods occur?

- Every 21 days or less
- Between 22-30 days
- Longer than 30 days

How long do your periods last?

- More than 7 days
- Between 5-7 days
- Less than 5 days
- Not applicable

How often do you change your pads/tampons on days of heaviest flow?

- | | |
|--|---|
| <input type="checkbox"/> Every hour to 2 hours | <input type="checkbox"/> Not sure |
| <input type="checkbox"/> Every 2-4 hours | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Every 4-6 hours | |

TESTS

Have you had any of the following tests for fibroids?

- | | |
|---|---|
| <input type="checkbox"/> Ultrasound scan | <input type="checkbox"/> D & C |
| <input type="checkbox"/> Pelvic examination | <input type="checkbox"/> CT scan or MRI |
| <input type="checkbox"/> PAP smear | <input type="checkbox"/> Fertility tests |
| <input type="checkbox"/> Blood tests | <input type="checkbox"/> Kept a menstrual diary |
| <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> None |
| <input type="checkbox"/> Hysteroscopy | <input type="checkbox"/> Don't know |

OTHER CONDITIONS

Have you previously been diagnosed with any of the following conditions?

- | | |
|--|---|
| <input type="checkbox"/> Endometriosis | |
| <input type="checkbox"/> Adenomyosis | <input type="checkbox"/> Ovarian cancer |
| <input type="checkbox"/> Abnormal uterine bleeding | <input type="checkbox"/> Polycystic ovarian disease |
| <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Endometrial polyps |
| <input type="checkbox"/> Pelvic adhesions | <input type="checkbox"/> Don't know |

PREVIOUS ADVICE

Have you previously been advised to undergo any of the following treatments for fibroids?

- | | |
|--|--|
| <input type="checkbox"/> Hormone therapy (such as Provera/Primolut, or the Pill) | |
| <input type="checkbox"/> Pain medication | <input type="checkbox"/> Myomectomy |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> D & C | <input type="checkbox"/> Infertility treatment |
| <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Arterial embolisation |
| <input type="checkbox"/> Hysteroscopy | <input type="checkbox"/> Counselling |
| <input type="checkbox"/> Endometrial ablation | <input type="checkbox"/> None |

CURRENT TREATMENT

Are you currently visiting any of the following Health Care Professionals for treatment of your fibroids?

- | |
|---|
| <input type="checkbox"/> General Practitioner |
| <input type="checkbox"/> Gynaecologist |
| <input type="checkbox"/> Complementary therapist (acupuncturist, naturopath, herbalist) |
| <input type="checkbox"/> Counsellor |
| <input type="checkbox"/> Other, please specify: |

FUTURE TREATMENT

What treatment options are you interested in?

- | | |
|---|--|
| <input type="checkbox"/> Drug therapy | <input type="checkbox"/> Complications and side-effects of treatment |
| <input type="checkbox"/> Surgery to shrink fibroids | <input type="checkbox"/> Clinical trials and research |
| <input type="checkbox"/> Surgery to remove fibroids | <input type="checkbox"/> Arterial embolisation |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Counselling and support |
| <input type="checkbox"/> Other, please specify: | |