raleigh radiology

Uterine Fibroid Embolization (UFE)
Patient Information

Patient:_____ Today's Date: ____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Signature: _____

Referring MD: _____ Primary MD, if different: _____

Primary Doctor, if different: _____

What is the reason for your visit today? _____

Do you have annual PAP smears? _____ Is your visit today related to the results of your PAP Smear? _____

Do you have heavy or prolonged menstrual cycles? _____ How long do your periods typically last? _____ days

How many feminine pads do you use per day? _____ Tampons? _____

Do you have increased frequency of: Urination? _____ Constipation? _____

Personal Facts

Marital Status: **Do you have children:** **Employment:**

What is your occupation: _____

Medical History

List all diseases from which you currently suffer: (heart disease, lung problems, high blood pressure, diabetes, Pelvic Inflammatory Disease, etc.) _____

_____

List all medical conditions you have had in the past: _____

_____

List all surgeries you have had, and date of surgery: _____

_____

_____

CURRENT MEDICATIONS – include all prescribed medications, vitamins, herbals, over-the-counter medications (aspirin, ibuprophen, Tylenol, etc.)

MEDICATION	DOSE	HOW OFTEN TAKEN

After completing this form, print, sign and bring with you to your appointment.