



### Johns Hopkins Fibroid Center Multidisciplinary Clinic Questionnaire

Full Name (Last, First, MI) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers (work, home, cell) \_\_\_\_\_ Email \_\_\_\_\_

1. When were you first diagnosed with fibroids? \_\_\_\_\_
2. What symptoms are you having? Circle all that apply.
  - a. Heavy menstrual bleeding
  - b. Bleeding between periods
  - c. Pelvic pressure or heaviness
  - d. Pressure on bladder –frequent urination or urination at night
  - e. Pain with intercourse
  - f. Pressure on bowels with constipation
  - g. Abdominal bloating
  - h. Back or leg pain
3. If you have heavy bleeding, how often you do change your pad/tampon?
  - a. Once an hour or less
  - b. Every 1-2 hours
  - c. Every 2 or more hours
4. If you have heavy bleeding, do you pass clots larger than the size of quarters?
  - a. Yes
  - b. No
5. If you have heavy bleeding, have you been diagnosed with anemia?
  - a. Yes
  - b. No
6. How long are your periods? \_\_\_\_\_
7. How many days from the beginning of one period to the beginning of the next period? \_\_\_\_\_
8. What evaluation of your fibroids have you had in the past? Circle all that apply.
  - a. Ultrasound
  - b. MRI
  - c. Biopsy of uterine lining
  - d. D&C
9. What treatment have you had for your fibroids previously? Circle all that apply.
  - a. Medical therapy (birth control pills or injections, IUD, Lupron® injection)
  - b. Hysteroscopic resection (removal of fibroid through vagina)
  - c. Myomectomy (abdominal or laparoscopic removal of fibroids, leaving uterus in place)
  - d. Uterine fibroid embolization
  - e. MR-guided focused ultrasound (also known as HI-FU, ExAblate®)
10. Do you desire to maintain your fertility?
  - a. Yes
  - b. No
11. Have you had previous abdominal surgery for conditions other than fibroids? If yes, please list.
  - a. Yes \_\_\_\_\_
  - b. No
12. Do you have any other medical problems? If yes, please list.
  - a. Yes \_\_\_\_\_
  - b. No
13. What medications are you taking? \_\_\_\_\_
14. Are you allergic to seafood or iodine or contrast dye?
  - a. Yes
  - b. No

**Please FAX to 410-614-8640**