Abnormal Uterine Bleeding/Pelvic Pain Consult Packet

Date of Consult _____

Patient name _____ __ **DOB** _____

Home Number _____ **Cell Number** _____

Is it ok to leave a detailed message (please circle) Yes No

Referring Doctor _____ **Phone Number** _____

Primary Care Doctor_____

Have you ever received IV contrast for CT scan or IVP in the past? *Yes or no*

If you received IV contrast did you have a reaction? Yes or No

Allergy to Latex? Yes or no

Allergies _____**Pharmacy**_____

Medication List	

Medical History	**Surgical History including Pelvic procedures**

VASCULAR INSTITUTE

SOCIAL HISTORY

Please circle the appropriate response.
Currently employed? NO / YES - Occupation _____
Retired? NO / YES
Disability? NO / YES

Marital Status: Single / Married / Separated / Divorced / Widowed

Tobacco Use:
Never / Current Use / Prior Use
Packs per day of Cigarettes:_
Number of Years: ___

Alcohol Use:
Never Rarely Occasionally Current Use Prior Use
Estimated Number of Drinks per Week:
Type of Alcohol: Beer Wine Spirits

Drug Use:
Never Rarely Occasionally Current Use Prior Use
Marijuana IV drugs Cocaine Methylphenidate

Sexually Active: YES NO
Contraceptives: None Birth Control Pills Condoms
Implanted Uterine Device: YES NO
Planning on additional children: YES NO

FAMILY HISTORY
Please list age, health status, and cause of death (if deceased).
Father _____Mother _____
Siblings _____Children _____

No knowledge of family medical history.
Please circle the appropriate response.
Does anyone in your family have diabetes? NO YES
Does anyone in your family have heart disease? NO YES
Does anyone in your family have high blood pressure? NO YES
Does anyone in your family have bleeding/clotting disorder? NO YES
Does anyone in your family have kidney disease? NO YES
Has anyone in your family had a Aortic Aneurysm? NO YES
Please further explain any "YES" responses to the above questions:

How old are you ?
How many times have you been pregnant?
Vaginal Birth: C-section:
How many children do you have?
How long have you had these symptoms? (months/years)
Date of last menstrual period?

Please describe the quality of pain you are having (circle*) Cramping, dull, sharp, constant, intermittent, back pain, pain during sex.*

Is the pain related to you menstrual cycle? *Yes or no*

- *Prior to period*
- *During period*
- *After cycle*

Do you have any of the following? *Frequency of urination, nocturia (waking to urinate), Constipation, bloating.*

How would you describe your menstrual cycle? *Regular or irregular.*

Do you suffer from any of the following? *(please circle all that apply) heavy bleeding, bleeding between periods, pain during your period, passage of clots, large amounts of liquid blood at once.*

How many days is your cycle*? First day of period one to first day of next period* _____*days*

How many days is your period? _____

How many heavy days do you have? _____

During heavy days do you use : *pads, tampons or both.*

During the heaviest times of your period, how often do you have to change the pad or tampon? _____*hours*

Have you ever been told you were anemic? *Yes or no*

Have you ever had a gynecologic infection (other then simple yeast infection)? *Yes or no*
When was your last PAP? _____*Where was your last PAP done?* _____

Have you ever had an endometrial biopsy done? Yes or no
When _____ Where_____

Have you ever had a pelvic ultrasound? Yes or no

When _____ Where_____

Have you ever had a pelvic MRI? Yes or no
When _____ Where_____

Please stop filling out form here

Physical Exam and Vital Signs	
Height	
Weight	
Blood pressure	
HR	
RR	
Temp	
Pulse Ox	