Uterine Artery Embolization (UAE) – Patient Intake Form

Patient Name: _____ Date of Birth _____

Date_____

1. Current Symptoms (check all that apply):

☐ Heavy menstrual bleeding

☐ Passing large blood clots

☐ Pelvic pain or cramping

☐ Pelvic pressure or fullness

☐ Abdominal bloating

☐ Frequent urination

☐ Constipation

☐ Pain with intercourse

☐ Fatigue or anemia

☐ Other: _____

How long have you had these symptoms?

_____

How much do these symptoms affect your daily life?

☐ Mild ☐ Moderate ☐ Severe

2. Menstrual History

Are your periods regular? ☐ Yes ☐ No

Average length of period: _____ days

How heavy is your bleeding? ☐ Light ☐ Moderate ☐ Heavy

Soaks a pad/tampon every 1–2 hours? ☐ Yes ☐ No

Date of last menstrual period (LMP): _____

3. Fibroid & Gynecologic History

Have you been diagnosed with uterine fibroids? ☐ Yes ☐ No

Date of diagnosis (if known): _____

Do you know the size or number of fibroids? ☐ Yes ☐ No

If yes, please describe: _____

Have you had pelvic imaging (Ultrasound or MRI)? ☐ Yes ☐ No

If yes, date and location: _____

Date of last Pap smear: _____

Any abnormal Pap results? ☐ Yes ☐ No

4. Pregnancy & Fertility

Are you currently pregnant or possibly pregnant? ☐ Yes ☐ No

Do you plan to become pregnant in the future? ☐ Yes ☐ No ☐ Unsure

Number of pregnancies: _____

Number of deliveries: _____

Prior C-sections or uterine surgery? ☐ Yes ☐ No

5. Prior Treatments for Fibroids (check all that apply):

☐ Birth control pills or hormonal therapy

☐ Progesterone or IUD

☐ GnRH injections (e.g., Lupron)

☐ Tranexamic acid (Lysteda)

☐ Myomectomy

☐ Endometrial ablation

☐ D&C

☐ No prior treatment

Did any treatment help? _____

6. Expectations & Goals

Main goals for treatment (check all that apply):

☐ Reduce bleeding ☐ Reduce pain/pressure ☐ Avoid surgery ☐ Other: _____

7. Additional Information

_____

_____

_____

Patient Signature: _____ Date: _____