Uterine Fibroid Questionnaire

Name: _____

SSN: _____

DOB: _____ **Age:** _____

Referring Physician: _____

Primary Physician: _____

What are your current symptoms or problems related to your fibroids?

_____
_____
_____
_____

How are your periods:

- **Bleeding: Mild/Moderate/Severe**
- **Pain: Mild/Moderate/Severe**
- **Duration of bleeding? _____ days.**
- **Date of last menstrual period?**

  _____

Have you ever been pregnant? Yes/No

How many pregnancies? _____

Children _____ **Miscarriages** _____

Tubal pregnancies _____ **Abortion** _____

History of fertility problems?

_____
_____
_____

Do you desire future pregnancy? Yes/No/Not Sure

Previous Treatment of Fibroids

1. Are you or have you ever been treated with hormonal therapy? (including birth control pills): Yes/No

If yes, list current medications:

_____
_____
_____

2. Surgical removal of fibroids (Myomectomy), date and outcome of surgery:

_____
_____
_____

Other Gynecological History

Surgeries or Procedures (date and outcome):

_____
_____
_____

Pelvic Inflammatory Disease? Yes/No

Treatment and Date: _____
_____

Sexually Transmitted Disease? Yes/No

Treatment and Date: _____
_____

Any family history of gynecological malignancies? _____

_____
_____
_____

General Medical Questions

Please list current medical conditions (asthma/respiratory problems, high blood pressure/diabetic/cardiac problems/bleeding/blood disorders):

_____

_____

_____

_____

Please list any medications you are currently taking (include dosage and how often you take it):

_____

_____

_____

Please list all ALLERGIES:

_____

_____

_____

Social History:

Do you smoke? Yes/No Packs/day: _____ For how many years? _____

Do you drink? Yes/No How much? _____ For how long? _____

Do you exercise? Yes/No How often? _____ Type of exercise? _____

What is your occupation? _____

Have you experienced any of the following?

- o **Weight loss**
- o **Fever**
- o **Chills**
- o **Bruising**
- o **Extremity Numbness**
- o **Loss of appetite**
- o **Extremity Weakness**
- o **Visual Loss or Changes**
- o **Palpitations**
- o **Productive or non-productive cough**
- o **Vomiting or Diarrhea**
- o **Leg cramps during sleep**
- o **Sores on legs or feet**
- o **Skin rashes**
- o **Back pain**
- o **Leg cramps when walking**
- o **Headache**
- o **Difficulty speaking**
- o **Chest pain**
- o **Shortness of breath**
- o **Abdominal pain**
- o **Urinary frequency or urgency**
- o **Other: _____**

Uterine Fibroid Questionnaire

Southern Vascular Institute
PATIENT INFORMATION

PATIENT INFORMATION (PLEASE PRINT)			**Social Security #**			
Last Name	First Name & MI	Name Called By:	Marital Status M S W D Sep	Date of Birth	Age	Sex M F

Street Address	City and State	Zip Code	Patient Home #
Patient's Employer	Occupation __Retired __Student		Patient Cell #
Employer's Street Address	City and State	Zip Code	Patient Work #

In Case of Emergency	Emergency Contact #	Patient E-Mail Address:
Referred By:	Primary Care Physician	Other Family Members Seen in Office

PERSON RESPONSIBLE FOR PAYMENT (If different from above.)

Last Name	First Name & MI	Relationship to Patient __Self __ Spouse __Father __Mother __Other	
Street Address	City and State	Zip Code	Home #
Employer			Cell #
Employer's Street Address	City and State	Zip Code	Work #

COMPLETE IF PATIENT IS A MINOR OR DEPENDENT STUDENT

Contact Name	Relationship to Patient: __Father/Stepfather __Mother/Stepmother __Guardian		Home #
Street Address	City and State	Zip Code	Cell #

I understand that I am financially responsible for all services rendered. If I am covered by an insurance company that requires a referral from my primary care physician, it is my responsibility to obtain that referral authorization prior to my visit. I will pay the charges I am responsible for today, whether it is a co-payment, deductible, co-insurance or payment in full by the following method ___ Cash ___ Check ___ Visa/MC ___ Discover ___ Patient Initials

PAYMENT AUTHORIZATION: I authorize insurance payment, if any, directly to Southern Vascular Institute. I realize I am responsible for non-covered services. ___ Patient Initials

INFORMATION RELEASE: I authorize Southern Vascular Institute to release to my insurance carriers or to the Social Security Administration and Health Care Financing Administration any information needed to determine benefits payable to related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. _____ Patient Initials

ACKNOWLEDGEMENT: I acknowledge all information above is accurate.

Signature of Patient or Legal Guardian, if a minor	Date

Southern Vascular Institute
Authorization of Use and Disclosure of Protected Health Information
(Page 1 of 2)

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we will leave a message stating our practice name, telephone number, and contact on the answer machine at your residence. Information will not be left with an unauthorized person. If you would like to have information released to someone other than yourself, please complete the following:

Appointment Reminders: The practice may use your information to remind you about upcoming appointments. Our practice will notify you of an upcoming appointment by telephone.

I _____, hereby authorize Southern Vascular Institute and staff to leave appointment reminders and medical information pertaining to my care at the following telephone numbers and I will assume responsibility to notify the practice whenever this information changes.

Home Telephone _____

Work Telephone _____

Cell Phone _____

If you have an answering machine, may we leave messages regarding appointments, treatments and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Southern Vascular Institute?

Yes _____ No _____ (Southern Vascular Institute will leave a message only when the answer machine identifies the patient/household by name).

If "No" how else may we contact you regarding this information? _____

Please list any other restrictions regarding messages or reminders about your healthcare: _____

_____

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "notice of Privacy Policies and Practices" brochure and/or consent will require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restriction on use and disclosure of your health information.

I would like the following restrictions regarding the use and disclosure of my health information:_____

_____

_____

Southern Vascular Institute
Authorization of Use and Disclosure of Protected Health Information
(Page 2 of 2)

Persons Authorized to Receive Information:

Print Name	**Contact Phone #**
_____ (Name of person / relation / organization	_____
_____ (Name of person / relation / organization	_____
_____ (Name of person / relation / organization	_____

Use and Disclosure of Information:

_____ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided by Southern Vascular Institute.

_____ I do not authorize the following information to be disclosed to any other parties except to me as the patient (Please specify"

_____

Expiration Date of Authorization: This authorization is effective through ____/____/____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Southern Vascular Institute. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Potential for Re-disclosure: The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Acknowledgement: Please sign below, acknowledging you have been offered an opportunity to review our Notice of Privacy Practices:

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

If you choose not to sign this acknowledgement form, please check the box, sign and date. ☐

_____
Signature of Patient Date

DIRECTIONS TO OUR OFFICE

DIRECTIONS FROM SPARTANBURG

Take I-85 South to Exit 56-57 (highway 14, the GSP airport exit). At the top of the exit, turn left. You will drive back over the over pass of the interstate. At the second light you come to turn left off of SC-14 going towards the hospital. Look for the hospital sign that is blue with white writing that says Medical office building directly on your right. Then take your immediate right onto a road that intersects the hospital the medical office building. Turn your immediate right again into the medical office building (Entrance B). There are water fountains and flag poles out front of the medical office building. Come through the double doors and take the elevators to the second floor. Our suite is 2400 on the left at the end of the hallway.

DIRECTIONS FROM GREENVILLE, ANDERSON, SENECA

Take I-85 North to Exit 56-57 (Highway 14, the GSP airport exit). At the top of the exit turn right. At the first light you come to turn left off of SC-14 going towards the hospital. Look for the hospital sign that is blue with white writing that says Medical office building directly on your right. Then take your immediate right onto a road that intersects the hospital the medical office building. Turn your immediate right again into the medical office building (Entrance B). There are water fountains and flag poles out front of the medical office building. Come through the double doors and take the elevators to the second floor. Our suite is 2400 on the left at the end of the hallway.

SOUTHERN VASCULAR INSTITUTE

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GREER, SC 29650

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