GEORGIA VASCULAR INSTITUTE

VASCULAR AND INTERVENTIONAL RADIOLOGY

Patient Name: ______________________________ DOB: ______________________

Uterine Fibroid Embolization History Form

CHIEF COMPLAINT

Bleeding: ☐ None ☐ Mild ☐ Moderate ☐ Severe

For how long: ____________ Is bleeding getting worse: ____________

LMP: ____________ Length: ____________ Regular: ____________ Irregular: ____________

Interval between periods: ____________ Interperiod bleeding: ____________

Pads, tampons, or both: ____________ Clots: ____________ Anemia: ____________

Pain/cramping: ☐ None ☐ Mild ☐ Moderate ☐ Severe For how long ____________

Worse during menses: ____________ Pressure: ____________ Bloating: ____________

Frequent urination: ____________ Constipation: ____________ Frequent bowel movements: ____________

Date of Fibroid Diagnosis: ____________________ Desire future pregnancy? ☐ Yes ☐ No

Comments: ____

____

GYNECOLOGY HISTORY

Adenomyosis ______________________

Fertility problems ______________________

Pregnancies ______________________

Endometriosis ______________________

PID ______________________

Other ______________________

PREVIOUS TREATMENT

Hormonal therapy ☐ Yes ☐ No Date: __________

Myomectomy ☐ Yes ☐ No Date: __________

U.F.E. ☐ Yes ☐ No Date: __________

D&C ☐ Yes ☐ No Date: __________

Cryoablation ☐ Yes ☐ No Date: __________

Other ☐ Yes ☐ No Date: __________

DIAGNOSTIC TESTS

Endometrial Biopsy ☐ Yes ☐ No Date: __________ Location: ______________________

Pap smear ☐ Yes ☐ No Date: __________ Location: ______________________

Hysteroscopy ☐ Yes ☐ No Date: __________ Location: ______________________

Ultrasound ☐ Yes ☐ No Date: __________ Location: ______________________

MRI ☐ Yes ☐ No Date: __________ Location: ______________________

Allergies: ____

Medications: ____

GEORGIA VASCULAR INSTITUTE

VASCULAR AND INTERVENTIONAL RADIOLOGY

Patient Registration Form

Name: ____ Today's Date: ______________________
FIRST MIDDLE LAST

Home Address: ____

City: _______________ State: _______________ Zip: _______________

Telephone: ( ) _______________ Birthdate: _______________ Age: _______________

Occupation: ______________________________ SSN: ____________________

Employer: ______________________________ Years There: _______________

Employer's Address: ____

City: _______________ State: _______________ Zip: _______________

Work Phone: ( ) _______________ Cell Phone: ( ) _______________

Email: ____

Referred by: ____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: ______________________________ Relationship to Patient: ___________________________

Home Address: ____

City: _______________ State: _______________ Zip: _______________

Telephone: ( ) _______________ Birthdate: _______________ Age: _______________

Occupation: ______________________________ SSN: _______________

Employer: ______________________________ Years There: _______________

Employer's Address: ____

City: _______________ State: _______________ Zip: _______________

Work Phone: ( ) _______________ Cell Phone: ( ) _______________

Email: ____

Name of Spouse: ______________________________ Birthdate: _______________ Age: _______________

Occupation: ______________________________ SSN: _______________

Employer: ______________________________ Years There: _______________

Employer's Address: ____

City: _______________ State: _______________ Zip: _______________

Employer's Telephone: ( ) _______________

In case of emergency, contact: ______________________________ Relationship: _______________

Home Phone: ( ) _______________ Work Phone: ( ) _______________

How did you learn about Georgia Vascular Institute? ____

Can we mail information to your home? ☐ Yes ☐ No

Can we leave a message for you at home? ☐ Yes ☐ No

Can we leave a message for you at work? ☐ Yes ☐ No

Can we send email to the address you provided? ☐ Yes ☐ No

GEORGIA VASCULAR INSTITUTE

VASCULAR AND INTERVENTIONAL RADIOLOGY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Name: ______________________ Age: ________ Date of Birth: ______________________

You were referred by: ______________________ Today's Date: ______________________

The reason why you are here today: ______________________

PAST MEDICAL HISTORY Check all that apply.

Condition			Condition		
Diabetes	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Emphysema/COPD	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Bleeding Tendency	☐ Yes	☐ No
Heart Problem	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Heart Attack/MI	☐ Yes	☐ No	Aneurysm	☐ Yes	☐ No
Heart Failure/CHF	☐ Yes	☐ No	Blood Clot/DVT	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No

Other: ______________________

PAST SURGICAL HISTORY Check all that apply and fill in the date (month and year).

Procedure	Date	Procedure	Date
☐ Heart bypass	________	☐ Aortic aneurysm	________
☐ Leg bypass R/L	________	☐ Brain aneurysm	________
☐ Vein surgery R/L	________	☐ Gallbladder	________
☐ Carotid surgery R/L	________	☐ Thyroid	________
☐ Angioplasty	________	☐ Gastric bypass	________
☐ Appendix	________	☐ Hernia repair	________

Other: ______________________

FAMILY MEDICAL HISTORY

	Father	Mother	Sibling
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Hypertension	☐	☐	☐
Heart problems	☐	☐	☐
Aneurysm	☐	☐	☐
Stroke	☐	☐	☐
Varicose veins	☐	☐	☐

SOCIAL HISTORY

Alcohol	☐ Yes ☐ No	If yes, how much ______
Tobacco/Smoking	☐ Yes ☐ No	If yes, packs/day ______
		If you quit, when ______
Drugs	☐ Yes ☐ No	If yes, type frequency ______
Do you live alone?	☐ Yes ☐ No	
Currently working?	☐ Yes ☐ No	If yes, type ______

MEDICATIONS Please list all the medications you are currently taking and dosages (Use additional separate medication list sheet if needed)

______

______

______

ALLERGIES ______

REVIEW OF SYSTEMS Please check all that apply.

Constitutional

Fever	☐ Yes ☐ No
Chills	☐ Yes ☐ No
Weight loss	☐ Yes ☐ No
	lbs ______
Weight gain	☐ Yes ☐ No
	lbs ______
Fatigue	☐ Yes ☐ No
Headaches	☐ Yes ☐ No

Skin

Ulcers	☐ Yes ☐ No
Rash	☐ Yes ☐ No
Itching	☐ Yes ☐ No
Changes in color	☐ Yes ☐ No
Breast lump	☐ Yes ☐ No
Breast discharge	☐ Yes ☐ No

Eyes

Glasses or contacts	☐ Yes ☐ No
Blurred vision	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No

ENT

Hearing loss	☐ Yes ☐ No
Earache or drainage	☐ Yes ☐ No
Sinus problems	☐ Yes ☐ No
Nose bleeds	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No
Swollen neck glands	☐ Yes ☐ No
Difficulty swallowing	☐ Yes ☐ No

Cardiovascular

Chest pain at rest ☐ Yes ☐ No
Chest pain with exertion ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No
Leg or ankle swelling ☐ Yes ☐ No

Respiratory

Short of breath-rest ☐ Yes ☐ No
Short of breath-walking ☐ Yes ☐ No
Wheezing or asthma ☐ Yes ☐ No
Chronic cough ☐ Yes ☐ No

Gastrointestinal

Nausea ☐ Yes ☐ No
Vomiting ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Abdominal pain ☐ Yes ☐ No
Blood in stools ☐ Yes ☐ No

Genitourinary

Frequent urination ☐ Yes ☐ No
Painful urination ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No
Incontinence ☐ Yes ☐ No
Prostate problems ☐ Yes ☐ No

Musculoskeletal

Joint pain ☐ Yes ☐ No
Joint swelling ☐ Yes ☐ No
Muscle pain/cramps ☐ Yes ☐ No
Back pain ☐ Yes ☐ No
Pain legs/calf ☐ Yes ☐ No
Cold extremities ☐ Yes ☐ No

Neurologic

Dizziness/lightheaded ☐ Yes ☐ No
Numbness/tingling ☐ Yes ☐ No
Tremors ☐ Yes ☐ No
Weakness ☐ Yes ☐ No

Psychiatric

Memory loss/confusion ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Insomnia ☐ Yes ☐ No

Endocrine

Excessive thirst ☐ Yes ☐ No
Heat/cold tolerance ☐ Yes ☐ No
Hormone problems ☐ Yes ☐ No

Hematologic/Immune

Easy bruising/bleeding ☐ Yes ☐ No
Slow to heal after cuts ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Hepatitis A,B,C ☐ Yes ☐ No
Clotting disorder ☐ Yes ☐ No

GEORGIA VASCULAR INSTITUTE

VASCULAR AND INTERVENTIONAL RADIOLOGY

Medication List

Patient Name: ______________________________ Date of birth: ____________________

MEDICATION	DOSAGE	FREQUENCY

PHARMACY: PHONE #:

GEORGIA VASCULAR INSTITUTE

VASCULAR AND INTERVENTIONAL RADIOLOGY

Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by Georgia Vascular Institute to any person or organization for the purposes of carrying out treatment, obtaining payment, or conducting certain healthcare operations. I understand that further information regarding how Georgia Vascular Institute will use and disclose my information can be found in Georgia Vascular Institute's Notice of Privacy Practices.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent, and
- I have received Georgia Vascular Institute's Notice of Privacy Practices currently in effect.

____

Print name of individual or personal representative

____ ____________________

Signature of individual or personal representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: ____

Unable to obtain written consent and acknowledgement because:

____ Individual refused

____ Emergency treatment situation

____ Individual not able to sign due to incompetence or other medical reason

____ Other: ____

____ ____________________

Staff Signature Date