MEDICAL IMAGING OF
LEHIGH VALLEY, P.C.
INTERVENTIONAL RADIOLOGY OFFICE

James A. Newcomb, M.D. • Darryn I. Shaff, M.D.
Errin J. Hoffman, M.D. • Stephen J. Huber, M.D.
Mark D. Swank, M.D. • Dana R. Burke, M.D., FSIR, FAHA
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UFE PATIENT QUESTIONNAIRE

Complete All Questions – Please Print

Date: _____

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ State / Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: S M W D Spouse Name: _____ Spouse DOB: _____

Occupation: _____ Religion: _____

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Other _____

Language Preference: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Pharmacy: _____ Phone Number: _____

Preferred Blood Work Lab: _____ Phone Number: _____

Do you have an Advanced Director or Living Will for Health Care? ☐ Yes ☐ No (if yes, please provide copy)

Do you have problems with anesthesia? ☐ Yes ☐ No

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Patient Name: _____

Have you ever had or been diagnosed with:

Anemia	☐ Yes ☐ No	Facial Weakness	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Balance disturbance	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No
Bleeding tendencies	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No
Blood clots	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Blurred vision	☐ Yes ☐ No	Irregular pulse	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Difficulty with speech	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No

Cancer ☐ Yes ☐ No Type: _____
Kidney Disease ☐ Yes ☐ No Explain: _____
Liver Disease ☐ Yes ☐ No Explain: _____
Other: _____

Surgical History:

Please list all prior surgeries.

Date	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Personal History:

Do you have children: ☐ Yes ☐ No If yes, how many: _____

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Patient Name: _____

Tobacco History:

☐ Current every day smoker # per day: _____ For how long: _____
☐ Current occasional smoker # per day: _____
☐ Former smoker When did you quit: _____
☐ Never smoked

Alcohol History:

☐ Consume alcohol daily How much per day: _____
☐ Consume alcohol socially How frequently: _____
☐ Never consume alcohol

Drug Use History:

Recreational drug use: ☐ Yes ☐ No

Allergies:

☐ Check here if you have no known allergies.
Latex allergy: ☐ Yes ☐ No
Iodine / Seafood allergy: ☐ Yes ☐ No
Medication(s) and reaction: _____

Mammography:

If you are a woman (40 - 69 years of age), did you have a mammogram within the past year?

☐ Yes, approximate date: _____ ☐ No ☐ Unsure

Medications:

Please list all prescription medications, herbal supplements, and over the counter medications – use an additional sheet of paper if necessary.

Medication	Dose	Frequency

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Patient Name: _____

Family History:

		Relation	Type (if known)
Diabetes:	☐ Yes ☐ No		
High Blood Pressure:	☐ Yes ☐ No		
Cancer:	☐ Yes ☐ No		
Strokes:	☐ Yes ☐ No		
Brain Aneurysms:	☐ Yes ☐ No		
Other:	☐ Yes ☐ No		

OB/GYN History:

What symptoms are you experiencing due to the presence of fibroids? Please circle the response that most closely reflects the severity of your symptoms (with zero being not at all, one to two being mild, three to four being moderate and five being severe).

	Severity						Duration (in months)
Abnormal bleeding:	0	1	2	3	4	5	
Menstrual cramps:	0	1	2	3	4	5	
Pelvic pain:	0	1	2	3	4	5	
Frequent urination:	0	1	2	3	4	5	
Abdominal bloating:	0	1	2	3	4	5	
Pain during intercourse:	0	1	2	3	4	5	

Other (please describe): _____

Which of the items above describes your most significant symptom: _____

Menstrual History:

Are you postmenopausal: ☐ Yes ☐ No
Are your periods regular: ☐ Yes ☐ No
Do you bleed between periods: ☐ Yes ☐ No
Do you pass clots: ☐ Yes ☐ No
Could you be pregnant: ☐ Yes ☐ No

Date of last menstrual period: _____

Number of days in your cycle: _____

How many pads or tampons are used during the heaviest day of you period: _____

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Patient Name: _____

Pregnancy History:

Number of pregnancies: _____ Number of live births: _____
Number of miscarriages: _____ Number of induced abortions: _____
Number of tubal (ectopic) pregnancies: _____ Number of cesarean sections: _____
Are you planning on having children in the future: ☐ Yes, likely within the next two years
☐ Would like to keep the option open
☐ No

Do you consider yourself infertile: ☐ Yes ☐ No
If yes, have you tried or had any of the following: ☐ Previous treatment for infertility
☐ Unprotected sex for 1 yr. w/o pregnancy
☐ 3 or more consecutive miscarriages

GYN Disorders:

Please indicate whether you have had any of the following gynecological disorders.

Endometriosis: ☐ Yes ☐ No Pelvic Inflammatory Disease: ☐ Yes ☐ No
Pelvic Adhesions: ☐ Yes ☐ No Adenomyosis: ☐ Yes ☐ No
Other (please describe): _____

Previous Diagnostic Tests:

☐ Ultrasound Date Performed: _____
☐ CT Scan Date Performed: _____
☐ MRI Date Performed: _____
☐ PAP Smear Date Performed: _____
☐ Endometrial Biopsy Date Performed: _____

Prior Treatment of Symptoms:

☐ Lupron injections Within the last 3 months: ☐ Yes ☐ No
How many injections: _____ Last injection date: _____

☐ Oral contraceptives Within the last 3 months: ☐ Yes ☐ No

☐ Non-steroid anti-inflammatory drugs (i.e. Advil) Within the last 3 months: ☐ Yes ☐ No

☐ Depo-Provera injection Within the last 3 months: ☐ Yes ☐ No

☐ Other (Provera, Aygestin, Megace, Synarel) Within the last 3 months: ☐ Yes ☐ No

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GYN Surgical History:

- ☐ Myomectomy Date performed: _____
- ☐ Myolysis Date performed: _____
- ☐ D&C Date performed: _____
- ☐ Ovarian cysterectomy Date performed: _____
- ☐ Endometrial ablation Date performed: _____
- ☐ Tubal ligation Date performed: _____
- ☐ Oophorectomy Date performed: _____

How did you first hear about this procedure: _____

The above information is accurate to the best of my knowledge.

_____ _____
Patient Signature Date

I have reviewed the information with the patient.

_____ _____
Signature of Individual Reviewing Form Date

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PATIENT PRIVACY FORM

Patient Name: _____ DOB: _____

As our patient, we may need to communicate with you when you are not in the practice. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care. Please note that an "appointment reminder" is not classified as medical information.

Please indicate your communication preferences below:

☐ I give permission to leave medical information pertaining to me, my dependent or child, at the numbers listed below:

Contact Method	Yes / No	Phone Number
Home	☐ Yes ☐ No	
Answering Machine	☐ Yes ☐ No	
Work Phone	☐ Yes ☐ No	
Cell Phone	☐ Yes ☐ No	
Pager	☐ Yes ☐ No	

Without specific permission, we will not release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner, etc.).

☐ Do not release medical information to anyone other than myself.

☐ I give permission to release medical information pertaining to me to the individual(s) listed below:

Name	Relationship	Phone Number

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

_____ _____
Signature of Patient or Legal Representative Date

_____
Signer's Printed Name