FUS-Center
am Helios Amper-Klinikum Dachau
Krankenhausstrasse 15
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Anamnesis Questionnaire

FUS
Fokussierter UltraSchall
Zentrum für Myomtherapie

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Dear patient,

We kindly ask you to take the time and legibly fill out this admitting form and afterwards submit it to our FUS Center along with your MRI scans.

Thank you!

Name/First name:_____ **Date of birth:** _____

Street: _____ **Postcode/Place:** _____

Phone no.: _____ **Email:** _____

Health insurance: _____ **Height**: _____ **Weight:** _____

Allergies: _____

Do you smoke? ☐ no ☐ yes

Since when (approx..) have you had problems with uterine myoma? _____

When was your last menstrual period (from – to) at the day of the MRI? _____

When was the last cancer screening pap smear at your gynecologist: _____

Do you currently and/or regularly take any medication (including hormones)? ☐ no ☐ yes, namely (name/s of the product/s): _____

Do you have (or have you had) any previous gynecological conditions:

☐ no ☐ yes, namely: _____

Do you suffer from any disease or dysfunction of the thyroid gland?

☐ no ☐ yes, namely: _____

Do you have an infectious disease (e.g. hepatitis, tuberculosis, HIV/AIDS)?

☐ no ☐ yes, namely: _____

Do you have any underlying diseases like e.g. diabetes, high blood pressure, epilepsy, Crohn's disease or ulcerative colitis (chronic inflammatory bowel disease) etc.? Please name any that apply:

_____

Have you had a thrombosis in the past? ☐ no ☐ yes

Do you have a coagulopathy / disease of the blood coagulation? ☐ no ☐ yes

Please name any that apply:

_____

Do you have any skin disease (e.g. neurodermatitis)? ☐ no ☐ yes

Please name any that apply: _____

Have you ever had abdominal surgery?

☐ no ☐ yes Please name any that apply: _____

Do you have scars from a previous surgery or a tattoo on your stomach?

☐ no ☐ yes, please name the surgery and the body part:_____

Please turn

Which myoma treatment has already been recommended to you by your gynecologist?

Hysterectomy (incl. cervix) via: ☐ laparoscopy ☐ vaginal ☐ abdominal section

Partial hysterectomy (cervix-conserving) via: ☐ laparoscopy ☐vaginal ☐ abdominal section

Uterus-conserving myomectomy via: ☐ laparoscopy ☐ vaginal ☐ abdominal section

Uterine fibroid embolisation: ☐ MR-guided focused ultrasound: ☐

Which symptoms do you experience?

☐ Menstrual-related pain ☐ Non-specific pain ☐ Pain during sexual intercourse

☐ (Manifest) iron deficiency ☐ Pressure on organs/urinary bladder

Heavy menstrual bleeding: ☐ no ☐ yes

If so, please quote the duration of your period: ___

How many tampons/sanitary pads do you need per day ?: ___

☐ Other symptoms: _____

Wish for child: ☐ no ☐ yes

Family planning completed: ☐ no ☐ yes

Have you entered menopause: ☐ no ☐ yes

Do you have a contraceptive/hormonal coil?

Should this report be forwarded to a particular doctor (e.g. gynecologist or family doctor?

☐ no ☐ yes

If so, please quote name and address:

_____

_____

How did you find out about us? _____

_____

Date, Signature