UTERUS TRANSPLANT MEDICAL HISTORY FORM

A health history will help us to determine your needs and is useful in evaluating your overall health status. Please take some time to complete this form in its entirety. Feel free to contact us with any questions.

PLEASE FAX COMPLETED FORM WITH DOCUMENTATION TO THE UTERUS TRANSPLANT OFFICE AT 205.996.9734 or email uterustransplant@uabmc.edu. Telephone: (205) 996-6060
Mailing address: 701 19th Street South, LHRB-728, Birmingham, AL 35249

Name _____ Date of Birth _____/ _____/ _____ Age _____

Address _____

Phone numbers: Home ( ) _____-_____ Work ( ) _____-_____ Mobile ( ) _____-_____

Email: _____

What is your preferred language? _____

Are you proficient in English? Yes _____ No _____

What is your highest level of education achieved?
High school/GED _____ Some college _____ Associate's degree _____ Bachelor's degree _____
Master's degree _____ Doctorate or professional degree _____ Other _____

What best describes your current employment status?
Full-time _____ Part-time _____ Student _____ Homemaker _____ Retired _____ Unemployed _____

What is your profession? _____

What is your relationship status? Single _____ Married _____ Divorced _____ Widowed _____

How long have you been with your current partner? _____

Medication or anesthesia allergies: Please list any medications you are allergic to, had a reaction to, or have difficulty taking. Please list the kind of reaction you had.

_____

_____

Would you accept a blood transfusion? Yes _____ No _____

GYNECOLOGICAL AND OBSTETRICS HISTORY:

Were you born with a uterus? Yes _____ No _____ Not sure _____

Do you currently have a uterus? Yes _____ No _____

If your uterus was removed, why? (Ex: fibroids, bleeding after a delivery, cervical cancer)

_____

If you were born without a properly formed uterus, do you have Mayer-Rokitansky-Kuster-Hauser (MRKH) syndrome? Yes _____ No _____ Not sure _____

Do you currently have a vagina? Yes _____ No _____ N/A _____

How was your vagina created*? Dilators _____ Surgery involving a skin graft _____
Surgery involving a bowel graft _____ Other _____ N/A _____

*Intended for patients with MRKH or other congenital abnormality

Do you currently have ovaries? Yes _____ No _____
If no, please provide reason _____

Have you ever been diagnosed with a condition that affects your ovaries? (Ex: ovarian cyst, teratoma, cancer) Yes _____ No _____
If yes, please provide more information _____

Have you had any type of surgery on the ovaries? (Ex: removal of ovarian cyst, removal of an ovary)
Yes _____ No _____ If yes, please provide more information _____

Have you ever received radiation treatment on your pelvis? Yes _____ No _____
If yes, please provide more information _____

Have you ever been treated by an infertility specialist or reproductive endocrinologist? Yes ____ No ____

Please specify what, if any, treatment the infertility specialist you saw performed for you: _____

_____

Does your doctor recommend you have yearly Pap smears? Yes ____ No ____

Have you ever had an abnormal Pap smear? Yes ____ No ____
If yes, please provide specific information _____

Have you ever been pregnant? Yes ____ No ____
If yes, please fill out the questions below. If no, please proceed to next section in bold.

- How many pregnancies have you had? _____
- What was the outcome of each pregnancy? (Ex. term birth, preterm birth, still birth, miscarriage) _____
  _____
- If you delivered your baby, how was the baby delivered? Vaginal ____ Cesarean section ____
- Please describe any complications associated with your pregnancy. (Ex: pre-eclampsia, preterm birth, gestational diabetes) _____ or N/A ____

ALTERNATIVE APPROACHES TO FAMILY PLANNING:

Have you considered utilizing a gestational carrier? Yes ____ No ____

Have you considered adoption? Yes ____ No ____

PERSONAL MEDICAL HISTORY:

Have you ever been diagnosed with any of the following illnesses or conditions? Please circle:

	No	Yes	Year Diagnosed
Heart attack	No	Yes	_____
Heart failure	No	Yes	_____
High blood pressure	No	Yes	_____
High cholesterol	No	Yes	_____
Heart arrhythmia	No	Yes	_____
Other cardiac disease: _____			
Diabetes	No	Yes	_____
Stroke	No	Yes	_____
Cancer*	No	Yes	_____
*Specify type and date of diagnosis: _____			
*Treatment received: _____			
Asthma	No	Yes	_____
Emphysema	No	Yes	_____
Chronic bronchitis	No	Yes	_____
Pulmonary embolism	No	Yes	_____
Other pulmonary disease	No	Yes	_____
Sickle cell disease	No	Yes	_____
Blood clotting disorder	No	Yes	_____
Bleeding disorder	No	Yes	_____
Deep vein thrombosis (DVT)	No	Yes	_____
Other blood disorder: _____			
Hepatitis	No	Yes	_____
Cirrhosis	No	Yes	_____

Other liver disease: _____

Pancreatitis	No	Yes	_____
Gallbladder stones	No	Yes	_____
Stomach ulcers	No	Yes	_____
Diverticulitis	No	Yes	_____
Crohn's disease	No	Yes	_____
Ulcerative colitis	No	Yes	_____

Other GI disease: _____

Rheumatoid arthritis	No	Yes	_____
Lupus	No	Yes	_____

Other autoimmune disorder: _____

Kidney stones	No	Yes	_____
Poor kidney function	No	Yes	_____
Solitary kidney	No	Yes	_____
Pelvic kidney	No	Yes	_____

Other kidney disease: _____

Gout	No	Yes	_____
Arthritis	No	Yes	_____

Depression	No	Yes	_____
Anxiety	No	Yes	_____
Eating disorder	No	Yes	_____
Other psychiatric disorder	No	Yes	_____

Seizure disorder	No	Yes	_____
Multiple sclerosis	No	Yes	_____

Other neurological disease: _____

HIV	No	Yes	_____
Hepatitis C	No	Yes	_____
Hepatitis B	No	Yes	_____
HPV	No	Yes	_____
Gonorrhea	No	Yes	_____
Chlamydia	No	Yes	_____
Syphilis	No	Yes	_____
Trichomoniasis	No	Yes	_____
Herpes simplex	No	Yes	_____
HSV	No	Yes	_____

Other infection: _____

ADDITIONAL MEDICAL OR PSYCHIATRIC HISTORY:

Please add any other medical problems you've had that are not listed above.

_____

_____

_____

_____

SURGICAL HISTORY:

	No	Yes	Year of Surgery
Appendectomy	No	Yes	_____
Gastric bypass	No	Yes	_____
Gallbladder removal	No	Yes	_____
Tonsillectomy	No	Yes	_____
Bowel resection	No	Yes	_____

ADDITIONAL SURGICAL HISTORY:

Please add any other surgeries you've had that are not listed above.

_____

_____

_____

_____

HOSPITALIZATIONS:

Please list any hospitalizations you've had for any reason, including any related to a diagnosis of psychiatric disorder or substance abuse.

_____

_____

_____

_____

SOCIAL HISTORY:

1. Do you currently smoke cigarettes or cigars? Yes ____ No ____

   If yes, what year did you start? _____

   How many packs per day? _____

   Have you ever used any tobacco or other nicotine products listed below?

   - Dipping/chewing tobacco Yes ____ No ____
   - Nicotine gum Yes ____ No ____
   - Nicotine patch Yes ____ No ____
   - Electronic cigarettes Yes ____ No ____
   - Vaping Yes ____ No ____
   - Other: _____

2. Do you drink alcohol, either now or in the past? Yes ____ No ____
   If yes, approximately how much/ how frequently? _____
   Date you last used alcohol _____/ _____/ _____

3. Have you ever used any substances or drugs not prescribed to you by a doctor?
   (Ex. marijuana, cocaine, narcotics, or herbal supplements) Yes ____ No ____
   What substance(s)? _____
   Last time used: _____/ _____/ _____

MEDICATION LIST:

Please list all medications you are taking, including over-the-counter medications.

Medication Name	Dose (mg / mcg / gm)	FREQUENCY How often do you take this medication?	How long have you been taking it?	Why do you take this medication (diagnosis)?	Who prescribed you this medication?