

☆ **30-DAY FOLLOW-UP - Pg 1**

* Date: ____ (d)/ ____ (m)/ ____ (y)

1. Recovery Time:

* Total days missed from work, including procedure: ____ days

* Total days until back to normal activity from procedure date: ____ days

2. * Re-interventions (check all that apply):

None
or

Myomectomy

Embolization

Hysteroscopy with resection

Hysteroscopy without resection

D & C

Hysterectomy

Endometrial Ablation

Other

☆ **30-DAY FOLLOW-UP - Pg 2**

3. * Adverse Events/Unanticipated consequences:

Event: Select all that apply.	If checked , indicate Associated Service Utilization: Select all that apply.	If Yes , specify Outcome:
<input type="checkbox"/> Has patient experienced any of the following events?		
<input type="checkbox"/> Recurrent Pain	<input type="checkbox"/> Unanticipated Office Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Emergency Room Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Hospitalization: Date of Admission: ____/____/____ Date of Discharge: ____/____/____	<input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Unresolved <input type="checkbox"/> Unknown <input type="checkbox"/> Death
<input type="checkbox"/> Sloughing of Submucosal Fibroid/Fibroid Passage	<input type="checkbox"/> Unanticipated Office Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Emergency Room Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Hospitalization: Date of Admission: ____/____/____ Date of Discharge: ____/____/____	<input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Unresolved <input type="checkbox"/> Unknown <input type="checkbox"/> Death
<input type="checkbox"/> New Hot Flashes/Night Sweats	<input type="checkbox"/> Unanticipated Office Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Emergency Room Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Hospitalization: Date of Admission: ____/____/____ Date of Discharge: ____/____/____	<input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Unresolved <input type="checkbox"/> Unknown <input type="checkbox"/> Death
<input type="checkbox"/> Radiation Skin Burn	<input type="checkbox"/> Unanticipated Office Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Emergency Room Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Hospitalization: Date of Admission: ____/____/____ Date of Discharge: ____/____/____	<input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Unresolved <input type="checkbox"/> Unknown <input type="checkbox"/> Death

☆ **30-DAY FOLLOW-UP - Pg 3**

Event: Select all that apply.	If checked , indicate Associated Service Utilization: Select all that apply.	If Yes , specify Outcome:
<input type="checkbox"/> Has patient experienced any of the following events?		
<input type="checkbox"/> Infection or Possible Infection	<input type="checkbox"/> Unanticipated Office Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Emergency Room Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Hospitalization: Date of Admission: ____/____/____ Date of Discharge: ____/____/____	<input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Unresolved <input type="checkbox"/> Unknown <input type="checkbox"/> Death
<input type="checkbox"/> Thromboembolism	<input type="checkbox"/> Unanticipated Office Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Emergency Room Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Hospitalization: Date of Admission: ____/____/____ Date of Discharge: ____/____/____	<input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Unresolved <input type="checkbox"/> Unknown <input type="checkbox"/> Death
<input type="checkbox"/> Spinal headache	<input type="checkbox"/> Unanticipated Office Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Emergency Room Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Hospitalization: Date of Admission: ____/____/____ Date of Discharge: ____/____/____	<input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Unresolved <input type="checkbox"/> Unknown <input type="checkbox"/> Death
<input type="checkbox"/> Persistent bleeding, hemorrhage following embolization	<input type="checkbox"/> Unanticipated Office Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Emergency Room Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Hospitalization: Date of Admission: ____/____/____ Date of Discharge: ____/____/____	<input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Unresolved <input type="checkbox"/> Unknown <input type="checkbox"/> Death
<input type="checkbox"/> Other - Specify: _____ _____	<input type="checkbox"/> Unanticipated Office Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Emergency Room Visit Date: ____/____/____ <input type="checkbox"/> Unanticipated Hospitalization: Date of Admission: ____/____/____ Date of Discharge: ____/____/____	<input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Unresolved <input type="checkbox"/> Unknown <input type="checkbox"/> Death