UTERINE FIBROID STUDY
BLOOD COLLECTION FORM

ID# : UFS «seq_no»
Name: «fname» «lname»

Date ☐☐ / ☐☐ / ☐☐ Time : ___/___ AM/PM
MO DY YR

New Address _____ New Home Phone _____
_____ New Work Phone _____

1. When was the last time you ate or drank anything other than water? ____:____am/pm

	YES	NO	REF	DK	NA
2. In the past three months, has a doctor told you that you are anemic?	**1**	**2**	**7**	**8**	**9**

3. What is the date when your most recent period started? ☐☐ / ☐☐ / ☐☐
mo / day / yr

4. Did you take any prescription or non-prescription medications in the past week? **1 2 7 8 9**

IF YES, SPECIFY?

5. Medication _____ ☐☐☐
   a. How recently did you take it? Was it within the last 24 hours? **1 2 7** 8 9

6. Medication _____ ☐☐☐
   a. How recently did you take it? Was it within the last 24 hours? **1 2 7 8 9**

7. Medication _____ ☐☐☐
   a. How recently did you take it? Was it within the last 24 hours? **1 2 7 8 9**

8. Did you have any of the following symptoms in the last week? **if so,** in the last 24 hours?

	1 2	**1 2**	
a. Fever	**Yes / No**	**Yes / No**	☐☐
b. Sore Throat	**Yes / No**	**Yes / No**	☐☐
c. Headache	**Yes / No**	**Yes / No**	☐☐
d. Cough or Runny Nose	**Yes / No**	**Yes / No**	☐☐
e. Upset Stomach	**Yes / No**	**Yes / No**	☐☐
f. Flu-like Body Ache	**Yes / No**	**Yes / No**	☐☐

9. First morning urine required? **Yes / No** ☐☐

10. Was first morning urine brought in? **Yes / No** ☐☐

IF NO:

a. Was urine collected at the clinic? **Yes / No** ☐☐