WOMEN'S CENTER FOR HEALTH

First Name: _____________ Last Name: _____________________ Date of Birth: _______________

Dear Patient:
In an effort to provide the best experience during your office visit today, please take a few minutes to read and complete the following questionnaire. This form is intended to stay current on important health issues affecting you and will allow the most efficient use of your time with the doctor. Thank you!

Contraception

1. Are you currently using hormonal contraception? YES NO **(circle one)**
2. If you do use hormonal contraception, which form/brand? ________________________
3. Are you planning on conceiving? YES NO **(circle one)**
4. If so, when? In next year _________ within 5 years __________
5. Would you like information on permanent birth control options? YES NO **(circle one)**

Menstrual Periods

1). Are you still menstruating? YES NO **(circle one)**
2). How long does your average monthly period last? _______ days
3). Do you ever feel as though your periods impact the quality of your life? YES NO **(circle one)**
4). Do you ever experience irregular or inconsistent bleeding patterns? YES NO **(circle one)**
5). Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? YES NO **(circle one)**

Urinary Health

1). Do you ever have urinary leaking when you cough, sneeze or laugh? YES NO **(circle one)**
2). Do you ever feel as though you have to urinate urgently? YES NO **(circle one)**
3). Do you feel like you have to urinate too frequently? YES NO **(circle one)**
4). Do you ever experience painful urination? YES NO **(circle one)**
5). Do you often wake up during the night to urinate? YES NO **(circle one)**
If yes, how often? ____________ Times per night

Vaginal Health

1). Do you suffer from vaginal dryness? YES NO **(circle one)**
2). Do you ever experience pain with intercourse? YES NO **(circle one)**
3). Do you experience vaginal itching or burning? YES NO **(circle one)**

4). Do you have frequent urinary track infections, bacterial infections or yeast infections? YES NO **(circle one)**

Sexual Health

1). In the past, was your level of sexual desire or interest good & satisfying to you? YES NO (circle one)
2). Has there been a decrease in your level of sexual desire or interest? YES NO (circle one)
3). Are you bothered by the decreased level of sexual desire or interest? YES NO (circle one)
4). Would you like your level of sexual desire or interest to increase? YES NO (circle one)
5). (Circle all factors that may apply) What factors do you feel may be contributing to your current decrease in sexual desire or interest? (A) An operation, depression, injuries, or other medical condition (B) Medications, drugs, or alcohol you are currently taking (C) Pregnancy, recent childbirth, menopausal symptoms (D) Other sexual issues you may be having (pain, decrease arousal or orgasm) (E) Your partner's sexual problems (F) Dissatisfaction with your relationship or partner (G) Stress or fatigue