Dear Patient,

In an effort to provide the best experience during your office visit today, please take a few minutes to complete the following questions. It will help us keep current on very important health issues affecting you and it will allow the most efficient use of time with the Doctor. Thank You!

CONTRACEPTION

1. Are you currently using hormonal contraception (birth control)? Yes___ No___
2. If so, what form of Birth Control are you using? _____
3. Are you planning your next child within the next year? Yes___ No___
4. Would you like information on a non-hormonal, non-surgical permanent Birth Control option performed in the comfort of our office? Yes___ No___

MENSTRUAL PERIODS

1. How long does your average Monthly Period last? ___ days
2. Do you ever feel as though your periods impact your quality of life? Yes___ No___
3. Do you every experience irregular or inconsistent bleeding patterns? Yes___ No___
4. Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? Yes___ No___

URINARY/BOWEL HEALTH

1. Do you ever leak urine when you cough, laugh or sneeze? Yes___ No___
2. Do you ever feel as though you have to urinate urgently? Yes___ No___
3. Do you feel like you have to urinate too frequently? Yes___ No___
4. Do you ever experience painful urination? Yes___ No___
5. Do you wake up more than 2 times a night to urinate? Yes___ No___
6. Do you experience any bowel issues with leaking or losing control of your bowel? Yes___ No___

AESTHETICS /OTHER *(Please indicate any area of interest)*

Dietary Supplements, Weight Loss Program, etc. _____ Gardasil Vaccination (Age 9 – 26) _____

********** **TO ELIMINATE THE NEED TO ANSWER PERSONAL QUESTIONS AT THE NURSES' STATIONS, PLEASE COMPLETE THE FOLLOWING**: **********

Name: _____ Age: _____ Height: _____

Drug Allergies: _____

Total # of Live Pregnancies: _____ # of Miscarriages/Abortions: _____# of Stillborns: _____

First Day of Last Menstrual Period: _____ Method of Birth Control (Hormonal/Surgical): _____

Last Pap Test: _____ Last Mammogram: _____ Last Dexa Scan: _____

Preferred Pharmacy – Name: _____ Street Address:_____

Preferred MAIL ORDER Pharmacy – Name: _____

Reason for This Visit: _____

_____