In an effort to provide the best experience during your office visit today and help us keep current on your health, please take a few minutes to complete the following questions. Thank you!

Name____Date______________

CONTRACEPTION

1. What is your current form of birth control? ____

2. How long have you been using your current form of birth control? *(Please check one)*
   _ Two years or fewer _ 3 to 5 years _ 6 to 10 years _ over 10 years

3. When are you planning to have another child? *(Please check one)*
   _ Within the next year _ Within the next 5 years
   _ Within the next 10 years _ My family is complete

4. When was your last menstrual period? ____

MENSTRUAL PERIODS

1. How long does your average monthly period last? ______________ days

2. Do you ever feel as though your periods impact the quality of your life? _ Yes _ No

3. Do you ever 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 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

AESTHETICS INTERESTS *(Please indicate any area of interest)*

_ Laser Hair Removal/Skin Rejuvenation _ Laser Vaginal Therapy _ Botox, Juvaderm, etc.

_ Weight Loss _ Body Contouring/CoolSculpting _ Facial Peels/Microdermabrasion

Are there any concerns/issues that you would like to discuss today? ______________________________

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