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In an effort to provide the best experience during you 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 less ___ 3-5 years ___ 6-10 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. Would you like information on a gentle, hormone free permanent birth control procedure 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 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

How did you hear about us? _____

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

_____

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