PATIENT NAME: _____ DOB:_____ DATE:_____

Female Symptom Monitor

Occupation:_____ Recreational Activities:_____

Presenting problems:

1. _____
2. _____

When did this start? _____

Please fill out each section that is relevant to your problem

Gynecological History:

What age did your period start?		
Is your cycle regular?	□ Yes □ No	How long is your cycle?
Do you suffer from PMS?	□ Yes □ No	
Is your bleeding heavy?	□ Yes □ No	
Do you have pain with your period?	□ Yes □ No	If yes, when?
Do you use tampons?	□ Yes □ No	
Do you have pain with insertion of a tampon?	□ Yes □ No	
Do you have excessive discharge?	□ Yes □ No	
Are you sexually active?	□ Yes □ No	
Do you use birth control?	□ Yes □ No	Type:
Do you experience pain with intercourse?	□ Yes □ No	Upon penetration?
Have you gone through menopause?	□ Yes □ No	If so, when?
Do you suffer from vaginal dryness?	□ Yes □ No	
Hormone replacement therapy If	□ Yes □ No	If yes, what?
Do you use lubrication?	□ Yes □ No	What type:

Pregnancy and Birth History:

# of pregnancies _____ # of live births _____ Wt. heaviest baby _____

Length pushing stage _____hours # of C-sections _____ # of vaginal deliveries _____

Did you have an epidural? □ Yes □ No

Did you have a vacuum-assisted delivery? □ Yes □ No Forceps? □ Yes □ No

Episiotomies? □ Yes □ No Any tearing? □ Yes □ No Grade of tear? _____

During my labour(s) and delivery, I felt supported and cared for:

o All or most of the time o Some of the time o A little bit o Not at all

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PATIENT NAME: _____ DOB:_____ DATE:_____

Were there times during labour and delivery that you were (or thought you were) in danger of death or injury? □ Yes □ No

Were there times when the baby was or seemed to be in danger during labour and delivery? □ Yes □ No

Do suffer/have you suffered from post-partum depression? □ Yes □ No

Do you have feelings of heaviness/pressure in your vagina? □ Yes □ No

Have you ever been told you have a prolapse? □ Yes □ No

Have you had any of the following medical procedures?

Appendectomy □ Yes □ No	Bartholin Cyst □ Yes □ No	Bowel Resection □ Yes □ No
Laparoscopy □ Yes □ No	Cystoscopy □ Yes □ No	Colostomy □ Yes □ No
TVT-TVT(O) □ Yes □ No	Gallbladder Removal □ Yes □ No	Hemorrhoid Surgery □ Yes □ No
Mesh Procedure □ Yes □ No	Prolapse/ Vaginal repair □ Yes □ No	Hysterectomy □ Yes □ No
Other		

Bladder Symptoms:

Did you have problems with your bladder during childhood?	□ Yes □ No □ Sometimes
Do you have leakage associated with sneezing, coughing, running and/or laughing?	□ Yes □ No □ Sometimes
Do you have leakage during intercourse?	□ Yes □ No □ Sometimes
Do you feel really strong sensations prior to voiding but don't leak?	□ Yes □ No □ Sometimes
Does your leakage occur after having a strong urge that feels uncontrollable?	□ Yes □ No □ Sometimes
Do you have pain when your bladder fills?	□ Yes □ No □ Sometimes
Does your pain improve when you void?	□ Yes □ No □ Sometimes
Do you have pain when you void?	□ Yes □ No □ Sometimes
Do you have to strain in order to empty your bladder?	□ Yes □ No □ Sometimes
Do you have difficulty starting your urine steam?	□ Yes □ No □ Sometimes
Do you have dribbling after you get up from the toilet?	□ Yes □ No □ Sometimes
Do you sit on the toilet?	□ Yes □ No □ Sometimes
Do you have incomplete emptying when you void and feel like you have to go again soon?	□ Yes □ No □ Sometimes
Do your bladder problems cause you to leak at night?	□ Yes □ No □ Sometimes
Does your incontinence fluctuate with your cycle?	□ Yes □ No □ Sometimes
Does your incontinence require you to wear pads?	□ Yes □ No □ Sometimes
If you answered yes or sometimes ,how often?	
Do you void during the day more than the average person (5-7x/day)?	□ Yes □ No □ Sometimes
If you answered yes or sometimes, how often?	
Do you need to get up at night to void?	□ Yes □ No □ Sometimes

PATIENT NAME: _____ DOB:_____ DATE:_____

If you answered yes or sometimes, how many times?

Fluid intake in 24 hours:

#_____ cups of water/day #_____cups of coffee/day

#_____cups of tea/day #_____cups of other fluids/day

Do you have any food allergies or sensitivities?

_____

_____

_____

Digestion & Bowel Function:

What is the frequency of your bowel movements?	
Do you regularly feel the urge to move your bowels?	□ Never □ Seldom □ Always
Do you have constipation?	□ Never □ Seldom □ Always
Do you strain to have a bowel movement?	□ Never □ Seldom □ Always
Do you have loose stools/diarrhea?	□ Never □ Seldom □ Always
Do you have bowel urgency that is difficult to control?	□ Never □ Seldom □ Always
Do you lose control of your bowels?	□ Never □ Seldom □ Always
Do you have incomplete emptying?	□ Never □ Seldom □ Always
Do you have pain with a bowel movement?	□ Never □ Seldom □ Always
Do you have pain after a bowel movement?	□ Never □ Seldom □ Always
Does it take longer than 5 minutes to have a bowel movement?	□ Never □ Seldom □ Always
Do you have bloating? (Increased pressure in abdomen)	□ Never □ Seldom □ Always
Do you experience a physical change in abdominal girth when your bowels are full (distension)?	□ Never □ Seldom □ Always
In your opinion, is your fibre intake	□ too low □ adequate □ too high
Do you regularly use	□ laxatives □ stool softeners □ natural products □ enemas

Have you ever been diagnosed with/think you have:

Irritable bowel syndrome When? _____ Who? _____

Ulcerative colitis When? _____ Who? _____

Crohn's Disease When? _____ Who? _____

Celiac Disease When? _____ Who? _____

Medical History:

Urinary tract infections	□ Yes □ No	How often?
Antibiotics recently?	□ Yes □ No	Last UTI?
Probiotics?	□ Yes □ No	Cranberry supplementation? □ Yes □ No

PATIENT NAME: _____ DOB:_____ DATE:_____

Smoker □ Yes □ No	# _____ packs/day	Chronic cough? □ Yes □ No	
Yeast infections	□ Yes □ No	How often?	
Last infection		Treatment	
Do you get blood in your urine? □ Yes □ No			
Allergies (including latex):	□ Yes □ No		
Low back problems	□ Yes □ No	Chronic? □ Yes □ No	
Mid back problems	□ Yes □ No	Chronic? □ Yes □ No	
Neck problems	□ Yes □ No	Chronic? □ Yes □ No	
Have you ever been treated for depression?	□ Yes □ No	What treatment?	
Have you ever been treated for anxiety?	□ Yes □ No	Whar treatment?	

On a scale from 1-10, please circle and rate how much this problem bothers you:

1 2 3 4 5 6 7 8 9 10

On a scale from 1-10, please circle and rate how motivated you are to correct this problem

1 2 3 4 5 6 7 8 9 10

DASS Questionnaire

Please read each statement and circle a number, 0, 1, 2, or 3, which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

S = _____ A = _____ D = _____

0 = It did not apply to me at all

1 = Applied to me to some degree or some of the time

2 = Applied to me a considerable degree, or a good part of the time

3 = Applied to me very much, or most of the time

I find it hard to wind down…… S 0 1 2 3

I was aware of dryness of my mouth…… A 0 1 2 3

I could not seem to experience any feeling at all…… D 0 1 2 3

I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion…… A 0 1 2 3

I found it difficult to work up the initiative to do things…… D 0 1 2 3

I tended to over-react to situations…… S 0 1 2 3

I experienced trembling (e.g. hands)…… A 0 1 2 3

I felt that I was using a lot of nervous energy…… S 0 1 2 3

I was worried about situations in which I might panic and make a fool of myself….. A 0 1 2 3

PATIENT NAME: _____ DOB:_____ DATE:_____

I felt that I had nothing to look forward to..... D 0 1 2 3
I found myself getting agitated..... S 0 1 2 3
I found it difficult to relax..... S 0 1 2 3
I felt down-hearted and blue..... D 0 1 2 3
I was intolerant of anything that kept me from getting on with what I was doing.... S 0 1 2 3
I felt I was close to panic..... A 0 1 2 3
I was unable to become enthusiastic about anything..... D 0 1 2 3
I felt I was not much of a person..... D 0 1 2 3
I felt that I was rather touchy..... S 0 1 2 3
I was aware of the action of my heart in the absence of physical exertion
(e.g. sense of heart rate increase, heart missing a beat)..... A 0 1 2 3
I felt scared without any good reason..... A 0 1 2 3
I felt that life was meaningless..... D 0 1 2 3