



*In an effort to provide the best experience during your office visit today and to 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)*  
 2 years or less       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. 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 affect 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       Vein Therapy       Botox, Juvaderm, Etc.