Patient name: _____ DOB: _____ Date: _____

Female Symptom Monitor

Occupation _____

Presenting problems _____

_____

_____

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? ☐ No ☐ Yes

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? ☐ No ☐ Yes If yes, when? _____

Do you use tampons? ☐ No ☐ Yes Do you have pain with insertion of a tampon? ☐ No ☐ Yes

Do you have excessive discharge? ☐ Yes ☐ No Sexually active? ☐ No ☐ Yes

Birth control? ☐ Yes ☐ No Type: _____ Pain with intercourse? ☐ Yes ☐ No

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

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 Tears? ☐ Yes ☐ No

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

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

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

Have you gone through menopause? ☐ Yes ☐ No If so, when? _____ Do you suffer from vaginal dryness? ☐ Yes ☐ No

Hormone replacement therapy ☐ Yes ☐ No If yes, what? _____

Do you use lubrication? ☐ Yes ☐ No Sometimes What type: _____

Patient name: _____ DOB: _____ Date: _____

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? If so, please provide approximate date:

Appendectomy	_____	Bartholin Cyst	_____	Bowel resection	_____
Laparoscopy	_____	Cystoscopy	_____	Colostomy	_____
TVT-TVT(O)	_____	Gallbladder removal	_____	Hemorrhoid surgery	_____
Mesh procedure	_____	Prolapse/Vaginal repair	_____	Hysterectomy	_____
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?	☐ No	☐ Yes	☐ 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

Patient name: _____ DOB: _____ Date: _____

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

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 # _____ alcoholic drinks/day

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?	☐ Always	☐ Seldom	☐ Never
Do you strain to have a bowel movement?	☐ Always	☐ Seldom	☐ Never
Do you have loose stools/diarrhea?	☐ Always	☐ Seldom	☐ Never
Do you have bowel urgency that is difficult to control?	☐ Always	☐ Seldom	☐ Never
Do you lose control of your bowels?	☐ Always	☐ Seldom	☐ Never
Do you have incomplete emptying?	☐ Always	☐ Seldom	☐ Never
Do you have pain with a bowel movement?	☐ Always	☐ Seldom	☐ Never
Do you have pain after a bowel movement?	☐ Always	☐ Seldom	☐ Never
Does it take longer than 5 minutes to have a bowel movement?	☐ Always	☐ Seldom	☐ Never
Do you have bloating? (Increased pressure in abdomen)	☐ Always	☐ Seldom	☐ Never
Do you experience a physical change in abdominal girth when your bowels are full (distension)?	☐ Always	☐ Seldom	☐ Never

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?	_____

Patient name: _____ DOB: _____ Date: _____

Do you have any food allergies or sensitivities? _____

_____

_____

Medical History

Urinary tract infections ☐ Yes ☐ No How often? _____

Antibiotics recently? ☐ Yes ☐ No Last UTI? _____

Probiotics? ☐ No ☐ Yes Cranberry supplementation? ☐ No ☐ Yes

Smoking ☐ 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): _____

Do you exercise? ☐ No ☐ Yes Type: _____ Frequency: _____

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? _____

Is/was treatment effective? ☐ No ☐ Yes

Have you ever been treated for anxiety? ☐ Yes ☐ No What treatment? _____

Is/was treatment effective? ☐ No ☐ Yes

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

Patient name: _____ DOB: _____ Date: _____

DASS Questionnaire

Please read each statement and circle a number, o, 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
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