

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: _____

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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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you have leakage associated with sneezing, coughing, running and/or laughing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you have leakage during intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you feel really strong sensations prior to voiding but don't leak?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Does your leakage occur after having a strong urge that feels uncontrollable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you have pain when your bladder fills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Does your pain improve when you void?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you have pain when you void?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you have to strain in order to empty your bladder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you have difficulty starting your urine stream?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you have dribbling after you get up from the toilet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you sit on the toilet?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Sometimes
Do you have incomplete emptying when you void and feel like you have to go again soon?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do your bladder problems cause you to leak at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Does your incontinence fluctuate with your cycle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes

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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? _____

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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

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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
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