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In an effort to provide the best experience during your office visit today and help us keep current on your health, please take a few minutes to complete the following questions. Thank you!

CONTRACEPTION

(If you no longer experience periods, please skip to the "Urinary Health" section).

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 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

MENSTRUAL PERIODS

(If you no longer experience periods, please skip to the next section).

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 ever experience painful urination? Yes No

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

E-Mail address;
