Patient Name: _____

Birth Date: _____ **Date completed:** _____

Vital Health
ENDOMETRIOSIS CENTER

Patient Questionnaire

PATIENT INFORMATION:

Height: _____ Weight: _____ Age: _____

Problems you would like Dr. Cook to address *(Required):*

What problems would you like to address with Dr. Cook?	How long have you had this problem?	What treatments have you previously tried?
1.		
2.		
3.		

How many days of each month are you pain free? _____

How many days a month are you in pain? _____

How many days a month are you **unable** to function? _____

What do you think is causing your pain? _____

Do you remember an event associated with the onset of your pain? _____

What helps to improve your pain? _____

What makes your pain worse? _____

Number of times pregnant	Number of deliveries	Number of Vaginal or C-Section deliveries	Weight of Babies	Episiotomy or Tears	Number of Living Children	Number of Miscarriages (M) Still Born (SB) or Pregnancy Terminations (PT)	If unable to conceive – circle infertility treatments you have tried?
0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	Vaginal: C-Sections:		Episiotomy: Tears:	0 1 2 3 4 5 6 7	Miscarriages: Still Born: Terminations:	IUI IVF Clomid Other:

Are you currently breastfeeding? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No How long have you been trying? _____

Organs Removed: ☐ **No organs have been removed**

Have you had any of the following organs removed, if so when:

☐ Uterus	☐ Right Ovary	☐ Left Ovary	☐ Appendix	☐ Gallbladder
____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

Other organs removed? If so what and when?

_____

Patient Name: _____

GYNECOLOGICAL HISTORY *(Required):*

FIRST PERIOD (Menarche):

Age of first period: _____
Were your first periods painful? Yes / No
Check what best describes your early periods experience:
☐ no cramps ☐ mild cramps ☐ moderate cramps ☐ killer cramps
Has the pain progressed (gotten worse over time)? Yes / No

PELVIC PAIN: ☐ Not Applicable

Age when pelvic pain began: _____
How many years have you suffered with this pain? _____
How many days of school, work or managing your home do you miss each month? _____
Is the pattern cyclic? Yes / No

CURRENT PERIODS: ☐ Not Applicable – Please explain: _____

Periods are: ☐ Light ☐ Moderate ☐ Heavy
Do you pass clots in menstrual flow? Yes / No
Are periods regular? Yes / No
Do you bleed between periods? Yes / No
How many days of menstrual flow? (on average) _____
How many days between your periods? (on average) _____
What cycle day does the pain start? _____

BIRTH CONTROL: ☐ I have never used Birth Control - skip to Numeric Pain Intensity Scale questions

CURRENT Birth control method: ☐ None ☐ Pills ☐ Condoms ☐ Tubal ligation ☐ IUD ☐ Other: _____
If currently taking birth control PILLS – list brand: _____
How long have you been using this brand: _____
How long have you been on all brands of birth control pills: _____

PAST Birth control method: ☐ None ☐ Pills ☐ Condoms ☐ Tubal ligation ☐ IUD ☐ Other: _____
If in the past you used birth control PILLS, did it help reduce your pain? Yes / No
If Yes, did the pill stop helping at some point in time? Yes / No
How long did you take it before it quit helping your pain: _____

Have you ***EVER*** experienced any side effects of birth control pills? Yes / No
If Yes, what side effects have you experienced?_____
List brands of birth control pills that did not agree with you: _____
List all brands of birth control pills that worked well for you: _____

Patient Name: _____

NUMERIC PAIN INTENSITY SCALE

Place an X over the level of pain that you are experiencing

A level of 0 is no pain

A level of **10 is the worst pain you can imagine**

OVERALL PAIN: ☐ **None**

1. Average overall Pain	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
2. Lowest pain level in last month	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
3. Greatest pain level in last month	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
4. Maximum pain level at which you can function	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10

CYCLIC PAIN: ☐ **None – why?** _____

1. Pain prior to period	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
2. Cramps prior to period	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
3. Pain during period	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
4. Cramps during period	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
5. Pain after period	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
6. Mid-cycle pain (Ovulation)	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10

LIBIDO and PAIN WITH SEX: ☐ **Never had sex** ☐ **No current sexual partner** ☐ **Sexually Active** ☐ **Stopped having sex at age:**_____

1. Deep pain with intercourse	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
2. Pain with penetration around vaginal opening	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
3. Vaginal burning pain with intercourse	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
4. Pain lasting ____ hours or days (circle) after sex	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
5. Pain with orgasm	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10
6.	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . .10

PAIN WITH BOWEL MOVEMENT / BOWEL SYMPTOMS: ☐ **None**

1. Pain **prior** to bowel movement **(Left Side)**	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . . 10
2. Pain **prior** to bowel movement (general)	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . . 10
3. Pain ***with*** bowel movement	0 . . . 1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . . 10

OTHER: ☐ **None**

1. Pain down left leg	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
2. Pain down right leg	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
3. Vulva burning or itching	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
4. Heavy periods	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
5. Irregular periods	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10

SYSTEMIC SYMPTOMS: ☐ **None**

1. Backache	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
2. Bloating	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
3. Chronic Yeast Infections	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
4. Depression	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
5. Fatigue	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
6. Migraine or headaches (Circle)	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
7. Muscle Pain: _____ (location)	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
8. Joint Pain: _____ (location)	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
9. Stress	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
10. Flu-like symptoms: _____ (list)	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
11. PMS Symptoms (list below)	
_____	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
_____	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10
_____	0 . . .1 .. . . 2 . . . 3 .. . . 4 . . . 5 . . . 6 . . . 7 . .. 8 . . . 9 . .. 10

Patient Name: _____

URINARY TRACT SYMPTOMS: ☐ **None**

Check all that apply

- ☐ Frequent Urination: # of times a day _____
- ☐ Get up to urinate more than 2 times a night
- ☐ Small volumes of urine
- ☐ Sensation of fullness or incomplete emptying after urination
- ☐ Loss of urine when coughing, laughing or sneezing
- ☐ Frequent bladder infections
- ☐ Pain with Urination
- ☐ Need to urinate with little warning
- ☐ Other: _____

CURRENT BOWEL/GASTROINTESTINAL SYMPTOMS: ☐ **None**

Check all that apply

- ☐ Pain **with** bowel movements (BM)
- ☐ Abdominal fullness, bloating or swelling
- ☐ Constipation
- ☐ Require laxative to have a bowel movement
- ☐ Fewer than 3 bowel movements a week
- ☐ Hard or lumpy stools
- ☐ Passing mucus (slippery white material) during BM
- ☐ Feeling of incomplete emptying after a BM
- ☐ Intestinal Cramping
- ☐ Diarrhea
- ☐ More than 3 bowel movements a day
- ☐ Loose or watery stools
- ☐ Blood with bowel movement
- ☐ Relief of pain with bowel movements
- ☐ Urgency–having to rush to bathroom for BM
- ☐ Other: _____

PAST MEDICAL HISTORY: ☐ **NONE**

Hospitalizations (excluding surgery and childbirth) _____

Have you had a severe accident(s): _____

Injuries (falls, back injury, accidents, etc.) _____

Medical Illnesses (past and present) _____

Have you ever been in an ICU – why?_____

Have you ever been unconscious - why? _____

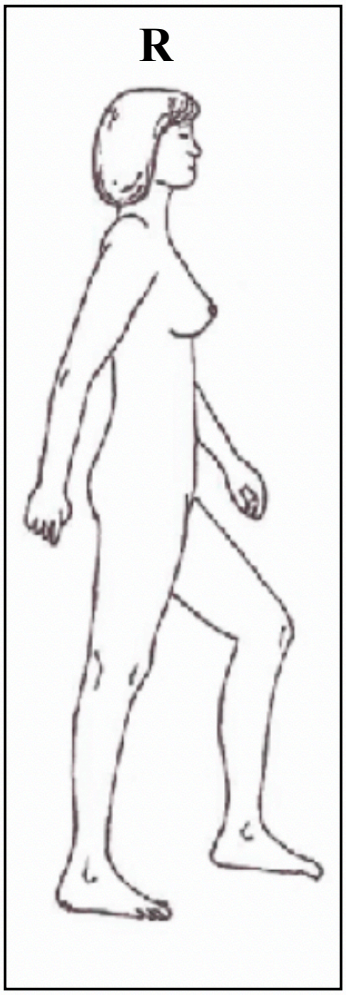
Check all that apply ☐ **NONE**

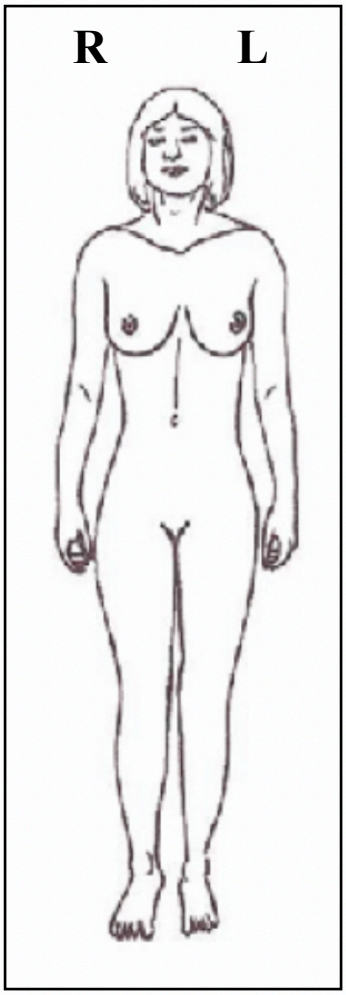
- ☐ Exposure to tick infested areas
- ☐ Frequent outdoor activities:
  - ☐ Hiking
  - ☐ Fishing
  - ☐ Hunting
  - ☐ Camping
  - ☐ Gardening
- ☐ Ticks found on pets
- ☐ Other family members with Lyme?
- ☐ Remember being bitten by a tick? When:_____
- ☐ Remember having a “bullseye rash”? When: _____
- ☐ Remember having any other rashes? When: _____

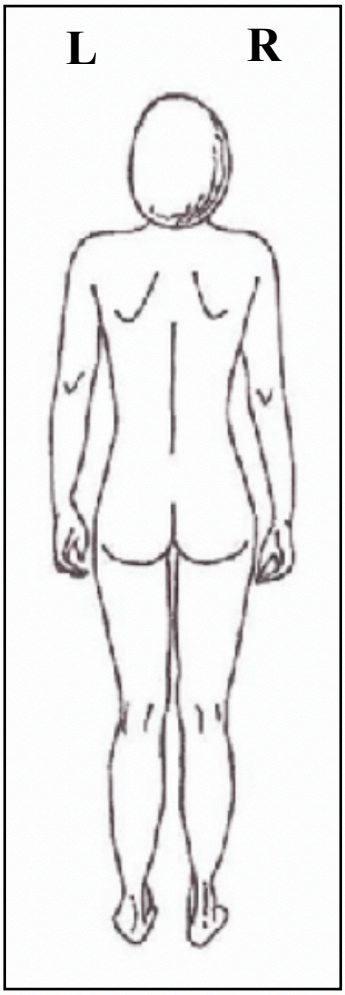
Patient Name: _____

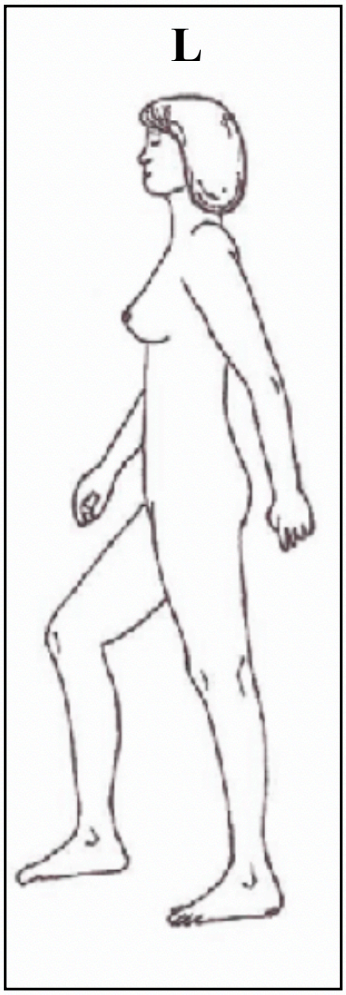
Pain Map

Please mark on the images below your areas of pain.





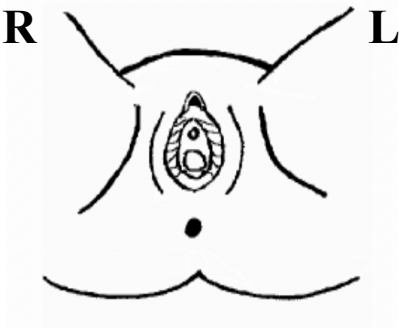




Vulvar / Perineal Pain

(Pain outside and around the vagina and anus)

If you have vulvar pain, shade the painful areas and write a number from 1 to 10 at the painful sites. (10=the most severe pain imaginable)



Patient Name: _____

ALL *CURRENT* HEALTH CARE PROVIDERS – PLUS *PAST* PELVIC PAIN PROVIDERS ☐ **Not Applicable**

What physicians or non-physician health care providers have you previously seen for treatment?

Name of Provider	Address	Phone/Fax	Are you sending Medical Records from this provider?
Current Pain Management Doctor:			

ALL PREVIOUS SURGICAL PROCEDURES ☐ **Not Applicable**

Please list all of your surgeries in chronological order, starting with your first procedure

Date	Hospital	Procedure	Percentage improved after the surgery?	How long did improvement last?	Is your Operation Report attached?

Patient Name: _____

CURRENT Non-PAIN MEDICATIONS: ☐ None
Please list all current medications

Name	Dose	Amount	Frequency	Prescribing doctor & their telephone No.

ALL CURRENT *PAIN* MEDICATIONS (Narcotic and Non-Narcotic): ☐ None

Name	Dose	Amount	Frequency	Prescribing doctor & their telephone No.

PRIOR PAIN MEDICATIONS (Narcotic and Non-Narcotic): that you have tried and the reason you stopped
☐ None

Name	Ineffective	Side Effects	Allergic Reaction
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

ALLERGIES AND SENSITIVITIES: ☐ Not Applicable
Please list prescription medications, environmental, latex allergies or sensitivities. Foods will be listed on another page.

Allergen	Reaction
Latex: Yes or No	

Patient Name: _____

PAST MEDICAL TREATMENTS AND PRESENT PROBLEMS

*Please **check** all boxes that apply.*
*Please **circle** all treatments &/or problems that have been helpful for you.*

MEDICATIONS: ☐ **None**

☐ **Lupron**
Have your been offered Lupron? YES / NO
If offered and you declined, why? _____

Have you taken Lupron? YES / NO
If yes what dose?
3.75 mg / month **OR** 11.25mg / 3 month

Total time on Lupron: _____yrs _____months

Date of last injection:___/___/___
Did LUPRON help symptoms? YES / NO

Did you experience any side effects on Lupron? YES / NO
Please list: _____

_____

☐ **Orilissa**
Have your been offered Orlissa? YES / NO –
If offered and you declined, Why? _____

Have you taken Orlissa? YES / NO
If yes what dose?
150mg once a day OR 200mg twice a day

Total time on Orlissa: _____yrs _____months

Date of last pill :___/___/___
Did Orlissa help symptoms? YES / NO

Did you experience any side effects on Orlissa? YES / NO
Please list: _____

_____

☐ Nerve Medications (Neurontin, etc.)
☐ Narcotic Pain Medications
☐ **Non**-narcotic Pain Medications
☐ Antidepressants
☐ Antifungal Meds
☐ Danazol
☐ Depo-Provera

PROCEDURES: ☐ **None**

☐ Nerve Blocks ☐ Cryo-ablation of nerve ☐ Implantable Devices ☐ Radiotherapy ☐ Other

SURGERY: ☐ **Not Applicable**

☐ Removal of Endometriosis
Date of Diagnosis:
____/____/____

☐ Bowel Resection
Date:
____/____/____

☐ Hernia Repair
Date:
____/____/____

☐ Removal of Scar Tissue
Date:
____/____/____

☐ Other:
____/____/____

Classification of Endometriosis:
☐ Stage I (Minimal). ☐ Stage II (Mild) ☐ Stage III (Moderate) ☐ Stage IV (Severe) ☐ Not Known

INFECTIONS: ☐ **None**

☐ Sexually Transmitted Diseases –
Please list:
☐ Epstein-Bar ☐ Hepatitis. B / C ☐ Urinary / Bladder ☐ Mononucleosis: ☐ Lyme ☐ Cold Sores ☐ Chronic Yeast Infections

THERAPEUTIC: ☐ **None**

☐ Biofeedback ☐ Massage ☐ Physical Therapy - Pelvic ☐ Physical Therapy - Other Describe: ☐ Chiropractic ☐ Psychotherapy

LIFE STYLE CHANGES I'VE MADE TO BE HEALTHER: ☐ **None**

☐ Diet/Nutrition ☐ Exercise ☐ Meditation ☐ Yoga ☐ Other

ALTERNATIVE: ☐ **None**

☐ Naturopathic* ☐ Traditional Chinese Supplements* ☐ Herbal Supplements* ☐ Homeopathic* ☐ Acupuncture

Provide Details:

CHILDHOOD: ☐ **None**

☐ Colic Child ☐ Bottle fed ☐ Ear Infections that required antibiotics ☐ Tonsils Removed at age: _____

Patient Name: _____

DIAGNOSTIC TESTS AND PROCEDURES:

Test	Test Date	Check if Abnormal	Test	Test Date	Check if Abnormal
Last Annual Exam		☐	**Thyroid Testing**		☐
PAP Smear		☐	**CT of _____**		☐
Mammogram		☐	**MRI of _____**		☐
Abdominal Ultra Sound		☐	**Bone Density Scan**		☐
Hysteroscopy with D&C		☐	**Stool Analysis**		☐
Hysterosalpingogram		☐	**Colonoscopy**		☐
Cervical or Vaginal Procedure (LEEP)		☐	**Barium Enema**		☐
CA-125		☐	**Upper G.I.**		☐
HPV Screen		☐	**HIDA Scan**		☐
Insulin Resistance		☐			

FAMILY HISTORY: (Mother=M, Father=F, Brother=B, Sister=S, Grandparent=G, Child=C, Aunt=A, Uncle=U)

Condition: *elaborate on type in box*	Circle which family member has this condition:	**Condition:** *elaborate on type in box*	Circle which family member has this condition:	**Condition:** *elaborate on type in box*	Circle which family member has this condition:
Allergies	M F B S G C A U	**Endometriosis**	M F B S G C A U	**IBS**	M F B S G C A U
Alcoholism	M F B S G C A U	**Epilepsy**	M F B S G C A U	**Kidney**	M F B S G C A U
Asthma	M F B S G C A U	**Fibromyalgia**	M F B S G C A U	**Lupus**	M F B S G C A U
Auto Immune Disease	M F B S G C A U	**Gallbladder Trouble**	M F B S G C A U	**Stroke**	M F B S G C A U
Bleeding Disorder	M F B S G C A U	**Heart Disease**	M F B S G C A U	**Thyroid**	M F B S G C A U
Depression	M F B S G C A U	**High Blood Pressure**	M F B S G C A U	**Other: _____**	M F B S G C A U
Diabetes	M F B S G C A U	**Hypoglycemia**	M F B S G C A U	**Other: _____**	M F B S G C A U
Cancer(s) Type(s): Breast Ovarian Colon Other:					M F B S G C A U

Patient Name: _____

REVIEW OF SYSTEMS: Check None or all that apply

Allergic/ Immunological	☐ None	☐ Pollen Allergy ☐ Food Allergy	☐ Dust Allergy ☐ Mold Allergy	☐ Autoimmune Disease: _____
Constitutional	☐ None	☐ Weight Loss ☐ Weight Gain	☐ Fatigue	☐ Low Grade Fever
Eyes	☐ None	☐ Vision Change	☐ Glasses	☐ Contacts
ENT/ Mouth	☐ None	☐ Ulcers ☐ Headaches	☐ Sinusitis	☐ Tinnitus
Cardiovascular	☐ None	☐ Chest Pain ☐ Pre-Hypertension	☐ Swelling Ankles ☐ Hypertension	☐ Palpitation
Respiratory	☐ None	☐ Wheezing ☐ Asthma	☐ Coughing Blood ☐ Cough	☐ Shortness of Breath
Gastrointestinal	☐ None	☐ Diarrhea ☐ Constipation ☐ Blood in Stool	☐ Painful bowel movements ☐ Vomiting ☐ Nausea	☐ Craving sweets
Genitourinary	☐ None	☐ Blood in Urine ☐ Frequency ☐ Interstitial Cystitis	☐ Low Sex Drive ☐ Urgency ☐ Incontinent	☐ Pain with Urination ☐ Incomplete Emptying
Musculoskeletal	☐ None	☐ Muscle Weakness	☐ Fibromyalgia	☐ Joint Pain
Breast	☐ None	☐ Painful Breast(s)	☐ Breast Discharge	☐ Breast Masses
Skin	☐ None	☐ Vulvadynia ☐ Nerve Pain	☐ Sensitive ☐ Rashes	☐ Psoriasis ☐ Eczema
Neurological	☐ None	☐ Passing Out	☐ Seizures	☐ Numbness
Psychiatric	☐ None ☐ Bipolar	☐ Crying ☐ Attention Deficit Disorder	☐ Depression ☐ Obsessive-Compulsive Disord.	☐ Suicide Attempt ☐ Schizophrenia
Endocrine	☐ None	☐ Diabetes ☐ Hyperthyroid	☐ Hypothyroid ☐ Hot Flashes	☐ Insulin Resistance ☐ Difficulty Concentrating
Hematology/ Lymphatic	☐ None	☐ Easy Bruising ☐ Anemia	☐ Bleeding Tendency ☐ Blood Transfusion	☐ Blood Clots (PE or DVT - not period clots)

Patient Name: _____

PERSONAL AND FAMILY HISTORY OF SUBSTANCE USE: ☐ **None**

Alcohol	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction	**Benzodiazepine**	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction
Prescription Drugs	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction	**Cocaine**	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction
Marijuana	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction	**Heroin**	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction
CBD Oil	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction	**Amphetamines**	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction
Cigarettes / E-Cigarettes:	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction	**Barbiturates**	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction
Illegal Drugs	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction	**Other**: _____	☐ Current. ☐ Past use ☐ Addiction Issues - I have sought help: Yes / No ☐ Family History of Addiction

ALCOHOL: ☐ **Not Applicable**

How many **alcoholic** beverages do you consume weekly **now**? _____

Did you drink more in the past? ☐ Yes ☐ No.

How many **alcoholic** beverages did you consume weekly? _____

CIGARETTES / E-CIGARETTES: ☐ **Not Applicable**

How many **cigarettes / e-cigarettes** do you smoke a day? _____ For how many years? _____

When do you smoke your 1st cigarette of the day?: _____

If a former smoker, when did you quit smoking?_____. For how many years? _____

SOCIAL HISTORY

Whom do you live with?	Were you ever the victim of sexual abuse as a child (<14 years old)? Yes / No
Education:	Have you ever been a victim of physical abuse by a family member?
What work are you trained for:	Have you been a victim of emotional abuse? Yes / No
What type of work are you doing:	Have you received therapy? Yes / No If yes, please describe:

Patient Name: _____

SEX AND INTIMACY ☐ **Never had sex** ☐ **No current sexual partner** ☐ **Sexually Active** ☐ **Stopped having sex at age:**_____

Are you happy and/or satisfied with your sex life?	☐ Yes ☐ No
Do you have pain with intercourse?	☐ Yes ☐ No
If yes, have you <u>always</u> had pain with intercourse?	☐ Yes ☐ No
If yes, is your pain with intercourse getting worse?	☐ Yes ☐ No
Is your partner happy with your sex life?	☐ Yes ☐ No
Is your sex life a source of tension in your relationship?	☐ Yes ☐ No
Do you experience vaginal dryness?	☐ Yes ☐ No
A level of zero is no desire and a level of 10 is the high desire: What is your desire level (libido) for sex:	0.. .1.. .2.. .3. ..4 ...5 ..6 ...7.. .8. ..9. ..10

Please check all the apply to you:

_____ Yes, I am interested in alternative medical treatments?
_____ Yes, I would like to avoid prescription medications if possible
_____ Yes, I would like the best that traditional and alternative medicine have to offer
_____ Maybe, I would consider alternative medicine in addition to traditional medications
_____ No, I am not interested in alternative medical treatments

WHAT ARE YOUR EXPECTATIONS OF TREATMENT?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____

DIET, EXERCISE and LIFE STYLE

Describe your diet on an average day. Please be as specific (and honest) as possible:

Breakfast: _____

Snack**:** _____

Lunch: _____

Snack**:** _____

Dinner: _____

Snack**:** _____

Do you react to foods? ☐ Yes ☐ No

Reactions: _____

Describe your weekly exercise routine:

Monday**:** _____

Tuesday**:** _____

Wednesday**:** _____

Thursday**:** _____

Friday**:** _____

Saturday**:** _____

Sunday**:** _____

List any chemicals, metals, dusts, molds or fumes to which you are repeatedly exposed:

_____

Are you willing to change your lifestyle/habits to improve your health? ☐ Yes ☐ No

Does your spiritual life play an important role in your life? ☐ Yes ☐ No

Patient Name: _____

Pelvic Pain and Urinary Frequency Questionnaire (PUF)

The questions below are asking about <u>BLADDER</u> pain only

Circle the answer that best describes how you feel for each question

		0	1	2	3	4	Symptom Score	Bother Score
1	**a.** How many times do you urinate during waking hours?	3 to 6	7 to 10	11 to 14	15 to 19	20+		
2	**a.** How many times do you urinate at night?	0	1	2	3	4+		
	b. If you get up at night to urinate, to what extent does it usually bother you?	None	Mild	Moderate	Severe			
3	**a.** If you are sexually active, do you now have or have you ever had pain or urgency to urinate during or after sexual intercourse?	Never	Occasionally	Usually	Always			
	b. If you are sexually active, has pain or urgency ever made you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
4	**a.** Do you have pain associated with your bladder or in your pelvis, vagina, lower abdomen, urethra or perineum?	Never	Occasionally	Usually	Always			
5	**a.** Do you still have urgency shortly after urinating?	Never	Occasionally	Usually	Always			
6	**a.** When you have pain is it usually _____?	None	Mild	Moderate	Severe			
	b. How often does your pain bother you?	Never	Occasionally	Usually	Always			
7	**a.** When you have urgency, is it usually ____?	None	Mild	Moderate	Severe			
	b. How often does the urgency bother you?	Never	Occasionally	Usually	Always			

SYMPTOM SCORE	
BOTHER SCORE	
TOTAL SCORE	

Patient Name: _____

Is there anything about your medical history that we have not asked you about that is important for us to know?

How has this chronic pelvic pain affected your life?

To return these forms you can either 1) scan and email your forms back to michelle@vitalhealth.com , 2) fax your forms to (408) 358-1009, or 3) mail them to 14830 Los Gatos Blvd., Suite 300 Los Gatos, CA 95032