

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

## Female Symptom Monitor

Occupation: \_\_\_\_\_ Recreational Activities: \_\_\_\_\_

Presenting problems:

1. \_\_\_\_\_
2. \_\_\_\_\_

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How long is your cycle?
Do you suffer from PMS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your bleeding heavy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have pain with your period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?
Do you use tampons?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have pain with insertion of a tampon?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have excessive discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:
Do you experience pain with intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Upon penetration?
Have you gone through menopause?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, when?
Do you suffer from vaginal dryness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hormone replacement therapy If	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what?
Do you use lubrication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What type:

### **Pregnancy and Birth History:**

# of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_ Wt. heaviest baby \_\_\_\_\_  
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 Any tearing?  Yes  No Grade of tear? \_\_\_\_\_

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



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

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?**

Appendectomy <input type="checkbox"/> Yes <input type="checkbox"/> No	Bartholin Cyst <input type="checkbox"/> Yes <input type="checkbox"/> No	Bowel Resection <input type="checkbox"/> Yes <input type="checkbox"/> No
Laparoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	Cystoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	Colostomy <input type="checkbox"/> Yes <input type="checkbox"/> No
TVT-TVT(O) <input type="checkbox"/> Yes <input type="checkbox"/> No	Gallbladder Removal <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoid Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No
Mesh Procedure <input type="checkbox"/> Yes <input type="checkbox"/> No	Prolapse/Vaginal repair <input type="checkbox"/> Yes <input type="checkbox"/> No	Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No
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"/> Yes <input type="checkbox"/> No <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
Does your incontinence require you to wear pads?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
If you answered yes or sometimes ,how often?	
Do you void during the day more than the average person (5-7x/day)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
If you answered yes or sometimes, how often?	
Do you need to get up at night to void?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes



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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

Do you have any food allergies or sensitivities?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Digestion & Bowel Function:***

What is the frequency of your bowel movements?	
Do you regularly feel the urge to move your bowels?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have constipation?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you strain to have a bowel movement?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have loose stools/diarrhea?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have bowel urgency that is difficult to control?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you lose control of your bowels?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have incomplete emptying?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have pain with a bowel movement?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have pain after a bowel movement?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Does it take longer than 5 minutes to have a bowel movement?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have bloating? (Increased pressure in abdomen)	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you experience a physical change in abdominal girth when your bowels are full (distension)?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
In your opinion, is your fibre intake	<input type="checkbox"/> too low <input type="checkbox"/> adequate <input type="checkbox"/> too high
Do you regularly use	<input type="checkbox"/> laxatives <input type="checkbox"/> stool softeners <input type="checkbox"/> natural products <input type="checkbox"/> 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? \_\_\_\_\_

***Medical History:***

Urinary tract infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?
Antibiotics recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last UTI?
Probiotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cranberry supplementation? <input type="checkbox"/> Yes <input type="checkbox"/> No



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Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No	# _____ packs/day	Chronic cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Yeast infections	<input type="checkbox"/> Yes <input type="checkbox"/> No		How often?	
Last infection			Treatment	
Do you get blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Allergies (including latex):	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Low back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		Chronic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mid back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		Chronic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neck problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		Chronic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been treated for depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No		What treatment?	
Have you ever been treated for anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Whar treatment?	

**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**

### **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



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- 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

