DC RANCH FAMILY MEDICINE & AESTHETICS

Female Health Assessment

Patient Name _____ Today's Date_____

Date of Birth _____

What was the first day of your last period? Date _____ or _____ > 1 year
Do you have children? ☐Yes ☐No If yes, gender & age(s)_____
Are you pregnant and or nursing? ☐Yes ☐No

Are you currently on any hormonal therapy? ☐Yes ☐No What type? _____
Have you had vaginal rejuvenation treatments? ☐Yes ☐No What type & how many? _____

When was your last Mammogram? Date _____ Imaging Facility _____ Results_____

Are you currently sexually active? ☐Yes ☐No Birth Control Method _____
Approximate date of last intercourse _____
If not currently sexually active, what is the reason? ☐ Too Painful ☐ I don't have a suitable partner
Other- please explain _____

The last time you had sexual intercourse did you experience:

No vaginal dryness_____ Mild vaginal dryness _____ Moderate to severe vaginal dryness_____

No vaginal pain_____ Vaginal pain like sandpaper _____ Vaginal pain like skin tearing_____

No discomfort at vaginal opening _____ Pain at opening like skin tearing _____

Vaginal pain and tightness at opening_____

Do you have external vulvar/external irritation or itching? ☐Yes ☐No

Do you have a history of recurrent vaginal bacterial or yeast infections? ☐Yes ☐No
If yes, how approximately how often do they occur? _____

Do you have a history of recurrent urinary tract infections? ☐Yes ☐No
If yes, how approximately how often do they occur? _____

Approximately how many times a day do you urinate? ☐ 3-6 ☐7-10 ☐11-14 ☐15-19 ☐20+

Do you have urinary urgency? ☐None ☐ Mild ☐Moderate ☐Severe

Approximately how many times at night do you get up to urinate? ☐0 ☐1 ☐2 ☐3 ☐4+

Do you leak urine when you cough, sneeze, and or laugh? ☐ Always ☐Sometimes ☐Never