Vibrant Life
Intimate Wellness

Women's Health History Form

Name _____ Prefer to be called _____

Birthday _____ SSN _____ Phone Days _____

Phone Evenings _____ Email _____

PCP _____ PCP Phone Number _____

How did you hear about our practice _____

Family History

Father Alive? Y/N, if no please list age at time of death. Please list medical conditions.

_____

Mother Alive? Y/N, if no please list age at time of death. Please list medical conditions.

_____

Brothers: #___ alive/medical conditions _____

Sisters: #___ alive/medical conditions _____

Children: # alive/medical conditions _____

Any unusual or rare diseases in your family or history we should know?

_____

Personal History

Do you smoke? __ Y __N If Yes, age of onset:____ # of packs per day: ____ Date Quit_____

Do you drink alcohol? __Y __N # of drinks per week _____

Have you used recreational drugs? __Y __N If yes, what have you used_____

Do you feel safe in your home? ___ Y ___N Any history of abusive relationship __Y __N

Have you been sexually assaulted __Y __N, If yes when: _____

Medications

Name	Dosage	Times per day	Name	Dosage	Times per day
1.			2.		
3.			4.		
5.			6.		
7.			8.		
9.			10.		
11.			12.		

Allergies or adverse reactions to medications: (list medication and type of reaction)

Hospitalizations and Surgeries

Past surgeries/Hospitalizations	Date/Age	Physician

Personal Medical History

Please list all health history diagnosis, conditions, and injury

Diagnosis/condition	Date	Physician Treating

Breast/Ovarian/Uterine Cancer History

Yes	No	Breast/Ovarian/Uterine	Self	Family Member	Age at Diagnosis
___	___	Breast cancer at age 50 or younger	_____	_____	_____
___	___	Breast Cancer over the age of 50	_____	_____	_____
___	___	Ovarian Cancer	_____	_____	_____
___	___	Pancreatic Cancer	_____	_____	_____
___	___	Uterine/Endometrial Cancer	_____	_____	_____

Menstrual History

Menopause: __ No __ Not Certain __ Yes (If yes, __ Natural or __ Surgical Age_____)

Menopause Symptoms __No __ Yes (If yes please fill out hormone questionnaire included)

Date of last menstrual period: _____

If still having menstrual periods are cycles: ___Light ___ Moderate ___Heavy ___ Clots

If menopausal do you experience post-menopausal spotting or bleeding?: ___Y ___N

Method of birth control (if not menopausal):

__ Condoms __Pills (OCP) __IUD __Depo Provera __Diaphragm
__Foam/spermicide/sponge __Contraceptive implant (arm) __Tubal Ligation
__Natural Family Planning __Vasectomy __Abstinence __ Other _____

Total Number of Pregnancies: _____ ____Vaginal Deliveries ____Cesarean

_____Miscarriages/or abortions ____ Number of Living Children

Pregnancy Complications: _____

Preventive and Health Maintenance History

Mammogram: Date _____ ___Normal ___Abnormal Facility Performed _____

Bone Density: Date _____ ___ Normal ___Abnormal Facility Performed _____

Pap Smear: Date _____ ___ Normal ___Abnormal Facility Performed_____

Do you have a history of an abnormal pap-smear? __Yes __No Explain: _____

Are you currently sexually active? __ Yes ___No

Do you have a history of any of the following:

___ Diabetes ___Heart Disease ___Neurological Disease/Disorder

___Spinal cord injury/surgery ___Brain injury ___ Sleep apnea

_____ _____

Patient Signature Date

_____ _____ _____

Printed Name Reviewed By Date

Female Hormone Questionnaire

Patient Name: _____ DOB: _____

Please circle one of the following categories below to let us know how you are feeling at today's appointment.

0 means you have no symptoms of symptoms of this type at all, 1 means you have very mild symptoms of this type, 5 would be a moderate symptoms and 10 would mean you have severe symptoms of this type.

	Low				Moderate					Severe		Comments, if any
Fatigue	0	1	2	3	4	5	6	7	8	9	10	_____
Weight Control	0	1	2	3	4	5	6	7	8	9	10	_____
Night Sweats	0	1	2	3	4	5	6	7	8	9	10	_____
Headaches	0	1	2	3	4	5	6	7	8	9	10	_____
Palpitations	0	1	2	3	4	5	6	7	8	9	10	_____
Painful Intercourse	0	1	2	3	4	5	6	7	8	9	10	_____
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10	_____
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10	_____
Muscle Weakness	0	1	2	3	4	5	6	7	8	9	10	_____
Low Sex Drive	0	1	2	3	4	5	6	7	8	9	10	_____
Hair Loss	0	1	2	3	4	5	6	7	8	9	10	_____
Body-Joint Pain	0	1	2	3	4	5	6	7	8	9	10	_____
Restless Leg Syndrome	0	1	2	3	4	5	6	7	8	9	10	_____
Poor Focus	0	1	2	3	4	5	6	7	8	9	10	_____
Memory Lapses	0	1	2	3	4	5	6	7	8	9	10	_____
Anxiety	0	1	2	3	4	5	6	7	8	9	10	_____
Irritability	0	1	2	3	4	5	6	7	8	9	10	_____
Mood Swings	0	1	2	3	4	5	6	7	8	9	10	_____
Depression	0	1	2	3	4	5	6	7	8	9	10	_____
Sleep Disturbances	0	1	2	3	4	5	6	7	8	9	10	_____
Dry Skin	0	1	2	3	4	5	6	7	8	9	10	_____
Decr Exercise Tolerance	0	1	2	3	4	5	6	7	8	9	10	_____

Patient Signature: _____ **Date:** _____

Female Sexual Function Index (FSFI) ©

Subject Identifier _____ Date _____

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

CHECK ONLY ONE BOX PER QUESTION.

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?

   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?

   - ☐ Very high
   - ☐ High
   - ☐ Moderate
   - ☐ Low
   - ☐ Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Very high
   - ☐ High
   - ☐ Moderate
   - ☐ Low
   - ☐ Very low or none at all

5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Very high confidence
   - ☐ High confidence
   - ☐ Moderate confidence
   - ☐ Low confidence
   - ☐ Very low or no confidence

6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

8. Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

9. Over the past 4 weeks, how often did you **maintain** your lubrication ("wetness") until completion of sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

17. Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain following vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Very high
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Very low or none at all

Thank you for completing this questionnaire

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