Aayla
SEXUAL WELLNESS AND AESTHETICS

Patient Health Questionnaire

Name: _____ Age:_____Weight:_____ Date of Birth:____/____/____

Address: _____Phone: _____

Address: _____EMail: _____

Pharmacy Name: _____Pharmacy Number: _____

How did you hear about us?: _____

My main concern today:_____

Chief Complaint/History of Present Illness

✓	Please check all that apply:	✓		✓	
	My inner lips are too long. I don't like the way they feel or look.		The inside of my vagina feels loose. I want it to feel tighter.		Painful Intercourse
	I am not happy with the appearance of my genitals		I have a low libido		Vaginal Dryness
	My outer lips appear deflated or saggy		My orgasms have decreased in intensity		Vulvar/vaginal itching
	I want a more youthful appearance to my vulva		I have recurrent UTI's		Lichen Sclerosis
	Urge Incontinence (run to the bathroom and cannot hold urine before reaching the toilet)		I want to learn about new treatments that may enhance my sexual experience		Other:
	Frequency (Frequent urination)		I am going through hormonal changes		Other:
	Stress Incontinence (leaking urine when you laugh, cough, sneeze)		Pelvic pain or heaviness		Other:

Have you ever been physically, sexually or emotionally abused?_____Yes_____No

Past Medical History

Please indicate whether you are currently being treated for or have been treated for any of these conditions in the past.

✓		✓		✓		✓		✓	
	Diabetes __Type 1 __ Type 2		Eczema		Atrial Fibrillation		Anemia		Migraine Headaches
	Hypertension		Skin Conditions		Asthma		Osteoporosis		Depression
	Stroke		Fibromyalgia		Lung Disease		Tuberculosis		Anxiety
	Head Injury		Arthritis		Stomach Problems/Ulcers		Lupus		Gout
	Epilepsy or Convulsions		GERD		Colitis		Phlebitis		Sleep Apnea
	High Cholesterol		Immune Deficiency		Irritable Bowel Syndrome		Thrombosis		Cancer (Type):
	Hyperthyroidism		Heart Disease		Keloids, trouble healing		Blood Clotting Disorder		
	Hypothyroidism		Heart Murmur		Kidney Disease		Hernia		Other:
	Psoriasis		Mitral Valve Prolapse		Kidney Stones		Glaucoma		

Urogynecology Surgery_____I have not had any previous Urogyn surgical procedures.

Please indicate whether and when you have had any of the following surgeries. Use last box in each category to indicate any surgeries not listed.

Type of Surgery	Date	Surgeon	Type of Surgery	Date	Surgeon
"Bladder Tack"			Vaginal Mesh		
Bladder Sling			Vaginal Hysterectomy		
Anterior Repair			Abdominal Hysterectomy		
Posterior Repair			Laparoscopic Hysterectomy		
Colpopexy / Sacralcolpopexy			Intracystic (Bladder) Botox Injection		
Burch Colposuspension			Urethral Dilation		
InterStim			Mesh Removal /Revision		
Urethral Bulking			Perineorrhaphy		
Cystoscopy			Tubal Ligation		
Cystoscopy with Hydrodistension			Bilateral Oophorectomy		

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Past General Surgical History _____ **I have not had any previous surgical procedures.**

Please indicate whether and when you have had any of the following surgeries. Use last box in each category to indicate any surgeries not listed.

✓		✓		✓		✓	
	Gallbladder		Appendectomy		Mastectomy		Thyroid Removal
	Facial Plastic Surgery		Knee Surgery		Brain Surgery		Bariatric Surgery
	Tummy Tuck		Colon/GI Surgery		Breast Implant		Other:
	Implantable Devices (pacemaker, etc)		Hip Surgery		Colon resection		Other:
	Heart Surgery		Back /Spinal Surgery		Liposuction		Other:

Do you have any drug allergies? _____

If so, to what? _____

Are you allergic to: ☐ **Milk Protein** ☐ **Egg** ☐ **Shellfish/Iodine** ☐ **Adhesive** ☐ **Latex**

Please list any medications you are taking. Include non-prescription medication, supplements, and vitamins.

Medication	Dosage

OB History: # of Pregnancies:_____ # of Vaginal Deliveries:_____ # of Caesarean Deliveries:_____

Last Pap Smear_____ Last Menstrual Period _____

Have you reached menopause? _____

Sexually Transmitted Infection History _____ **I have no history of STD's or STI's**

✓		✓		✓	
	Herpes		Gonorrhea		Syphilis
	Trichomonas		HPV		HIV
	Condyloma (genital warts)		Hepatitis B		AIDS
	Chlamydia		Hepatitis C		Other:

Non-Surgical UROGYN Medications/Treatments Previously Tried

✓	MEDICATION	Dose	✓	MEDICATION	Dose	✓	MEDICATION	Dose	✓	THERAPY
	Premarin			Myrbetriq			Elmiron			Intermittent Self Catheterization
	Estradiol			Gemtesa			Singulair			Pessary
	Estrace			Detrol (Tolterodine)			Uribel			Bladder Instillations
	Intrarosa			Oxybutynin (Ditropan)			Pyridium			Kegels
	Imvexxy			Vesicare (Solifenacin)			Cranberry Supplement			E-Stim or Interstim
	Osphena			Toviaz			Aloe Vera Capsules			Pelvic Floor Physical Therapy
	Flomax (Tamsulosin)			Enablex (Darifenacin)			Linzess			Lifestyle Modifications
	Amitriptyline			Sanctura (Trospium)			Trulance			Bladder Training

Family History _____ **I am adopted and I do not know my family medical history.**

Please indicate whether anyone in your family has had the following conditions including mother, father, sister, brother, maternal/paternal parents, son, daughter, aunt, uncle.

✓	Condition	Family Member	✓	Condition	Family Member
	Bladder Cancer			Colon/Other GI Cancer	
	Interstitial Cystitis			Breast Cancer	
	Urinary Incontinence			Other Cancer:	
	Kidney Stones			Heart Disease	
	Kidney Disease			Diabetes:	
	Ovarian Cancer			Other Disease:	

Patient Health Questionnaire

Personal/Social History:

Marital Status : _____ Single _____Widowed _____Married

_____ Separated _____Divorced _____Other

Children: _____

Are you sexually active? _____

What method of birth control do you currently use? (circle) None Condoms Pill Patch Arm Implant Vaginal Ring IUD Other

Alcohol Consumption: _____None _____Rarely _____Social _____1-2 Drinks Daily/Weekly _____ 3+ Drinks Daily/Weekly

Tobacco Use: _____Never Smoked _____Current Smoker: _____Cigarettes/Vape Pen _____ Smokeless Tobacco

_____Previous Smoker: How many years quit? _____

Street Drugs Used: _____None _____Marijuana _____Cocaine _____IV drug use _____Other

Caffeinated Beverages: _____None _____Rarely _____Occasionally _____Daily _____Weekly

_____Coffee _____Tea _____Soda _____ Other #_____Of Beverages per Day

Exercise: _____None _____1 day/wk _____2-3 days/wk _____over 3 days/wk

Type of Exercise:

_____Running _____Walking _____Swimming _____Biking
_____Aerobics _____Tennis _____Golf _____Roller blading
_____Weightlifting _____Horseback riding _____Scuba diving
_____Yoga Other: _____

Have you ever had legal problems? (specify) _____

Have you ever been under the care of a psychologist or psychiatrist? _____

Have you been involved in a medical malpractice lawsuit? _____

Do you accept that medicine and surgery may have unpredictable outcomes and complications? _____

I have completed this Medical Questionnaire to the best of my knowledge and ability. Aayla Sexual Wellness and Aesthetics will not be held responsible for any missing or incorrect information.

Patient Signature_____ **Date** _____