

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### Symptom Monitor

Presenting problems \_\_\_\_\_  
\_\_\_\_\_

When did this start? \_\_\_\_\_  
\_\_\_\_\_

Occupation/hobbies \_\_\_\_\_

#### Gynecological History – please complete the following section if this applies to you

What age did your period start? \_\_\_\_\_ Is your cycle regular? No Yes

How long is your cycle? \_\_\_\_\_ Do you suffer from PMS? Yes No Is your bleeding heavy? Yes No

Do you have pain with your period? No Yes If yes, when? \_\_\_\_\_

Do you use tampons? No Yes Do you have pain with insertion of a tampon? No Yes

Do you have excessive discharge? Yes No Sexually active? No Yes

Birth control? Yes No Type: \_\_\_\_\_ Pain with intercourse? Yes No

# of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_ Wt. heaviest baby \_\_\_\_\_ lbs \_\_\_\_\_ oz

Age of child(ren) \_\_\_\_\_ Length pushing stage \_\_\_\_\_ hours

# of vaginal deliveries \_\_\_\_\_ # of C-sections \_\_\_\_\_ Forceps? Yes No

Did you have an epidural? Yes No Did you have a vacuum-assisted delivery? Yes No

Episiotomies? Yes No Tears? 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 \_\_\_\_\_

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 & delivery? Yes No

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

Have you gone through menopause? Yes No If so, when? \_\_\_\_\_ Do you suffer from vaginal dryness? Yes No

Hormone replacement therapy Yes No If yes, what? \_\_\_\_\_

Do you use lubrication? Yes No Sometimes What type: \_\_\_\_\_

Do you use vaginal moisturizer Yes No Have you ever been told you have a prolapse? Yes No

If yes, what type? \_\_\_\_\_

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Do you physically feel something coming out of your vagina (with your hand) Yes No Do you have feelings of heaviness/pressure in your vagina Yes No

**Prostate/Penile Health - please complete the following section if this applies to you**

Last PSA score: \_\_\_\_\_ When? \_\_\_\_\_ Last digital rectal exam? \_\_\_\_\_

Does your prostate get painful/irritated?  Yes  No Has your prostate fluid been expressed and tested?  Yes  No

Do you have painful erections?  Yes  No Can you achieve a satisfactory erection?  No  Yes

Do you have premature ejaculation?  Yes  No

Do you have pain during intercourse?  Yes  No When? \_\_\_\_\_

**Have you had any of the following medical procedures? If so, please provide the approximate date:**

Appendectomy \_\_\_\_\_ Bartholin Cyst \_\_\_\_\_ Bowel resection \_\_\_\_\_

Laparoscopy \_\_\_\_\_ Cystoscopy \_\_\_\_\_ Colonoscopy \_\_\_\_\_

TVT-TVT(O) \_\_\_\_\_ Gallbladder removal \_\_\_\_\_ Hemorrhoid surgery \_\_\_\_\_

Mesh procedure \_\_\_\_\_ Prolapse/Vaginal repair \_\_\_\_\_ Hysterectomy \_\_\_\_\_

Colostomy \_\_\_\_\_ Vasectomy \_\_\_\_\_ Prostatectomy \_\_\_\_\_

Hernia repair \_\_\_\_\_ Urodynamics \_\_\_\_\_ Other \_\_\_\_\_

**Bladder Symptoms - please complete the following section if this applies to you**

Did you have problems with your bladder during childhood?  Yes  No  Sometimes

Do you have leakage associated with sneezing, coughing, running and/or laughing? Other \_\_\_\_\_  Yes  No  Sometimes

Do you have leakage during intercourse?  Yes  No  Sometimes

Do you feel really strong sensations prior to voiding but don't leak?  Yes  No  Sometimes

Does your leakage occur after having a strong urge that feels uncontrollable?  Yes  No  Sometimes

Do you have pain when your bladder fills?  Yes  No  Sometimes

Does your pain improve when you void/urinate?  Yes  No  Sometimes

Do you have pain when you void/urinate?  Yes  No  Sometimes

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- Do you have to strain in order to empty your bladder?  Yes  No  Sometimes
- Do you have difficulty starting your urine stream?  Yes  No  Sometimes
- Do you have dribbling after you get up from the toilet?  Yes  No  Sometimes
- Do you sit on the toilet?  No  Yes  Sometimes
- Do you have incomplete emptying when you void and feel like you have to go again soon?  Yes  No  Sometimes
- Do your bladder problems cause you to leak in bed at night?  Yes  No  Sometimes
- Does your incontinence fluctuate with your cycle?  Yes  No  Sometimes
- Does your incontinence require you to wear pads?  Yes  No  Sometimes

If you answered yes or sometimes, how often? \_\_\_\_\_ Type of pads \_\_\_\_\_

- Do you void during the day more than the average person (5-7x/day)?  Yes  No  Sometimes

If you answered yes or sometimes, how often? \_\_\_\_\_

- Do you need to get up at night to void?  Yes  No  Sometimes

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 # \_\_\_\_\_ alcoholic drinks/day/week/month

### Digestion & Bowel Function

- What is the frequency of your bowel movements? \_\_\_\_\_
- Do you regularly feel the urge to move your bowels?  Never  Seldom  Always
- Do you have constipation?  Always  Seldom  Never
- Do you strain to have a bowel movement?  Always  Seldom  Never
- Do you splint or assist to pass stool?  Always  Seldom  Never
- Do you have loose stools/diarrhea?  Always  Seldom  Never
- Do you use your finger to help evacuate?  Always  Seldom  Never
- Do you have bowel urgency that is difficult to control?  Always  Seldom  Never
- Do you have accidental bowel leakage?  Always  Seldom  Never
- Do you have incomplete emptying?  Always  Seldom  Never
- Do you have pain with a bowel movement?  Always  Seldom  Never
- Do you have pain after a bowel movement?  Always  Seldom  Never
- Does it take longer than 5 minutes to have a bowel movement?  Always  Seldom  Never
- Do you have bloating? (Increased pressure in abdomen)  Always  Seldom  Never

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Do you experience a physical change in abdominal girth when your bowels are full (distension)?  Always  Seldom  Never

In your opinion, is your fibre intake  Too low  Adequate  Too high

Do you regularly use  Laxatives  Stool softeners  Natural products  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? \_\_\_\_\_

Do you have any food allergies or sensitivities? \_\_\_\_\_

### Medical History

Urinary tract infections  Yes  No How often? \_\_\_\_\_

Antibiotics recently?  Yes  No Last UTI? \_\_\_\_\_

Probiotics?  No  Yes Cranberry supplementation?  No  Yes

Smoking  Yes  No # \_\_\_\_\_ packs/day Chronic cough  Yes  No

Yeast infections  Yes  No How often? \_\_\_\_\_

Last infection \_\_\_\_\_ Treatment \_\_\_\_\_

Do you get blood in your urine?  Yes  No

Allergies (including latex): \_\_\_\_\_

Do you exercise?  No  Yes Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Low back problems  Yes  No Chronic?  Yes  No

Mid back problems  Yes  No Chronic?  Yes  No

Neck problems  Yes  No Chronic?  Yes  No

Have you ever been treated for depression?  Yes  No What treatment? \_\_\_\_\_

Is/was treatment effective?  No  Yes

Have you ever been treated for anxiety?  Yes  No What treatment? \_\_\_\_\_

Is/was treatment effective?  No  Yes

Have you ever been diagnosed with a mental health condition?  No  Yes If yes, what? \_\_\_\_\_

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***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

**20 Questions For Vitamin D Deficiency: Do You Experience The Following Symptoms?**

Smooth muscle	Shortness of breath	No	Yes
	Vascular headaches	No	Yes
	Wheezing after exercise	No	Yes
	Frequent urination	No	Yes
	Constipation	No	Yes
Skeletal muscle	Leg cramps	No	Yes
	Muscle tension	No	Yes
	Fasciculations (eg. eye twitches)	No	Yes
	Double vision	No	Yes
	Myalgia	No	Yes
	Restless legs	No	Yes
	Back pain	No	Yes
Cardiovascular	Trigger point pain	No	Yes
	Palpitations	No	Yes
	Arrhythmias	No	Yes
	High blood pressure	No	Yes
Brain	Depression	No	Yes
	Decreased concentration	No	Yes
	Headaches	No	Yes
	Increased anxiety	No	Yes
Other	Dark chocolate craving (especially after period)	No	Yes
	Difficulty falling asleep	No	Yes
	Decreased symptoms after Epsom salt bath	No	Yes

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## 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
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