FEMININE HEALTH QUESTIONNAIRE

Date: ____ / _____ / _____

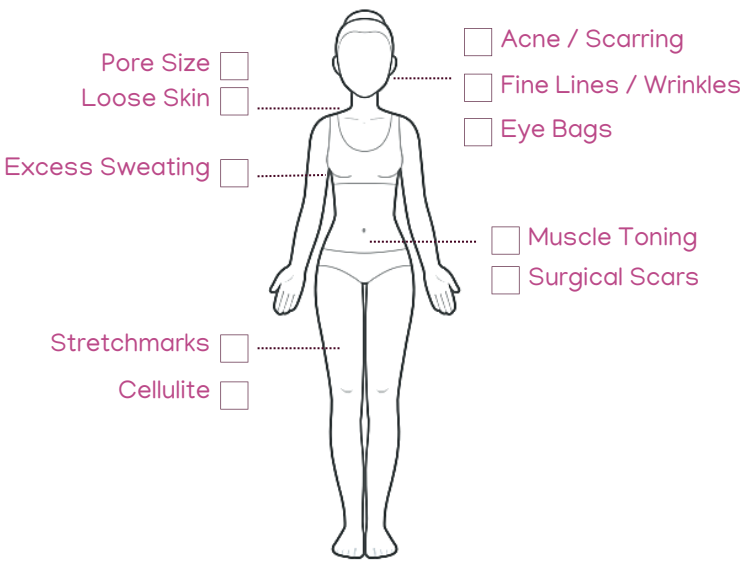
Full Name: _____

Phone: _____

Email: _____

CLARK MEDICAL CARE

Question Please circle a number at the end of each questions or check N/A if the question does not apply					
Pain during intercourse? ☐ N/A	1	2	3	4	5
Vaginal Dryness? ☐ N/A	1	2	3	4	5
Urinary Frequency / Urgency ☐ N/A	1	2	3	4	5
Leakage during the day ☐ N/A	1	2	3	4	5
How many times do you get up to go to the bathroom at night? ☐ N/A	1	2	3	4	5
Weak pelvic floor / Prolapse (vaginal bulge) ☐ N/A	1	2	3	4	5
How happy are you with the external appearance of your labia? ☐ N/A	1	2	3	4	5
Do your symptoms affect : sleep, athletics, travel or social activities? ☐ N/A	1	2	3	4	5



Do you have any other comments, questions or concerns?