Dr. Mayur V. Patel

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Dear Patient,

In an effort to provide the best experience during your office visit today, please take a few minutes to complete the following questions. It will help us keep current on very important health issues affecting you and it will allow the most efficient use of time with the Doctor. Thank You!

CONTRACEPTION

1. Are you currently using hormonal contraception (birth control)? Yes___ No___

2. If so, what form of Birth Control are you using? _____

3. When are you planning your next child?
   Within the next year___, Within the next 5 years___, Within the next 10 years___, My family is complete___.

4. Would you like information on a non-hormonal, non-surgical
   Permanent Birth Control option performed in the comfort of our office? Yes___ No___

MENSTRUAL PERIODS

1. Does your period last longer than seven days? Yes___ No___

2. Do you ever feel as though your periods impact the quality of your life Yes___ No___

3. Do you ever experience irregular or inconsistent bleeding patterns Yes___ No___

4. Are you interested in learning more about a one time treatment
   For heavy bleeding that is safe, non-surgical and may be provided
   in the comfort of our office? Yes___ No___

URINARY HEALTH

1. Do you experience leakage while laughing, sneezing, jumping or
   Performing other movements that put pressure on the bladder? Yes___ No___

2. Do you frequently experience a sudden and immediate urge
   To urinate? Yes___ No___

3. Have you noticed a change in your frequency of urination? Yes___ No___

4. Would you like information on a minimally invasive incontinence
   procedure? Yes___ No___

PROLAPSE

1. Have you ever felt a bulge or lump in your vagina? Yes___ No___

2. Do you feel like something is falling out of your vagina? Yes___ No___

3. Do you experience pain or discomfort during intercourse? Yes___ No___

4. Do you experience vaginal pain, pressure, irritation, bleeding
   or spotting? Yes___ No___