CENTER FOR
PELVIC HEALTH AND WELLNESS

Full Name:_____Date of Birth: _____

Reason for visit today (please check one):

____ **Annual gyn exam without gyn issues**

____ **Annual gyn exam with gyn issues**: Please circle appropriate issues below. These issues may be addressed at a separate visit from your annual exam. Your insurance may allocate a co-payment for the gyn portion of your visit when combined with an annual exam.

____ **Gyn issues without an annual exam**: Please circle appropriate issues below.

If you have specific gyn issues you would like addressed, please circle all that apply to you:

Menstrual Irregularities:
heavy menses
bleeding between periods
lack of periods
painful periods
premenstrual syndrome

Perimenopausal/Menopausal Symptoms:
anxiety
depressive mood
forgetfulness
difficulty with concentration
fatigue
hot flushes
pain with sexual activity
loss of libido
problems with orgasm
mood swings
night sweats
sleep disturbance
weight gain
vaginal dryness
hormone questions/therapy

Non-menstrual Bleeding:
bleeding after sexual activity
postmenopausal bleeding
bleeding not related to menses

Vaginal/Vulvar Issues:
vaginal/vulvar itching
vaginal/vulvar pain
vaginal/vulvar dryness
vaginal/vulvar mass or lump
vaginal discharge
vaginal odor

Other Issues:
breast mass
breast pain
abnormal pap
sexually transmitted disease
birth control
pelvic pain
urinary issues

Other gyn issues, not listed above: _____

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