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? ______________________________

Patient name: ______________________________ DOB: _____________ Date: _____________

| | | | | | |
|---|---|---|---|---|---|
| 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 | _______________ | Urodyanmics | _______________ | 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 |

Patient name: ______________________ DOB: __________ Date: __________

| | | | |
|---|---|---|---|
| Do you have to strain in order to empty your bladder? | ☐ Yes | ☐ No | ☐ Sometimes |
| Do you have difficulty starting your urine steam? | ☐ 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 |

Patient name: ______________________ DOB: __________ Date: __________

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? ______________________

Patient name: ________________________________ DOB: ______________ Date: ______________

***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

## Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

*Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).*

| Insomnia Problem | None | Mild | Moderate | Severe | Very Severe |
|---|---|---|---|---|---|
| 1. Difficulty falling asleep | 0 | 1 | 2 | 3 | 4 |
| 2. Difficulty staying asleep | 0 | 1 | 2 | 3 | 4 |
| 3. Problems waking up too early | 0 | 1 | 2 | 3 | 4 |

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

| Very Satisfied | Satisfied | Moderately Satisfied | Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

| Not at all Noticeable | A Little | Somewhat | Much | Very Much Noticeable |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

6. How WORRIED/DISTRESSED are you about your current sleep problem?

| Not at all Worried | A Little | Somewhat | Much | Very Much Worried |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

| Not at all Interfering | A Little | Somewhat | Much | Very Much Interfering |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |



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Patient name: ______________________________ DOB: _____________ Date: _____________

# DASS Questionnaire

Please read each statement and circle a number, o, 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**

| Statement | | | | | |
|---|---|---|---|---|---|
| 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 |



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