Dear ____________________:

Welcome to the Christiana Care Center for Uro-Gynecology and Pelvic Surgery!

Your appointment with ________________ is scheduled on _____________ at ____________ AM/PM
at the following location:

- **Medical Arts Pavilion (MAP) II.**
  - Suite 1208
  - 4735 Ogletown-Stanton Road
  - Newark, DE 19713

- **Smyrna Health & Wellness Center**
  - 100 S. Main Street Building C; Suite 215
  - Smyrna, DE 19977

- **Christiana Care Concord Center**
  - 161 Wilmington-West Chester Pike
  - Chadds Ford, PA 19317

Enclosed in this packet is a medical history form as well as a current medication list for you to complete. Please list all of your medication(s) with the strength and amount you take and also how often you take them.

Also, you will find a bladder diary and also a pelvic floor questionnaire. These allow us to better understand our pelvic floor complaints. Instructions on how to complete these are found on the forms themselves.

If you have any questions regarding these papers, feel free to contact our office at the phone number listed above.

**For those patients that have an HMO insurance plan:** You are responsible for obtaining any referral you may need from your referring physician, PCP (primary/family doctor) and/or your insurance company.

Please obtain your referral (if needed) prior to your appointment day and have a copy with you when you arrive to your appointment or have your doctor’s office fax a copy to us prior to your appointment day.

*If you are unsure as to whether or not a referral is needed, please call your insurance company for clarification.

If your insurance requires you to pay a copay, please come prepared to pay the copay at the time of visit.
We accept cash, check and all major credit cards (except American Express).

We look forward to meeting you!

Sincerely,

Babak Vakili, MD
Howard Goldstein, DO
Emily Saks, MD
Matthew Fagan, MD

Leia Collins, PA-C
Colleen Deturk, WNHP
Helen Cohen, WNHP
Amanda Wardwell, WNHP
Patient Name: (Last) __________________ (First) __________________ (Middle) ____________

Address: ________________________________________________________________

City: ___________________ State: ________ Zip: __________ Country: _______________

Birth Date: ___________ Phone: _______________ Work: _______________ Cell: ___________

Contact By: Home __ Cell __ Work __ Email Address: ___________________________ Sex: □ Male □ Female

Marital Status: Single __ Married __ Divorced __ Widowed __ Separated __ Partner __ Other __ SSN: _______ - ______ - _______

Race: □ American Indian or Alaska Native □ Asian □ Asian and Black or African American □ Asian and White □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White or Caucasian □ Undetermined

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino □ Other or Undetermined □ Preferred Language: ____________________________

Employment Status: (mark all that apply) □ Full-time □ Part-time □ Self-Employed □ Retired □ Student □ Child □ Unemployed □ Other: ____________________________

Primary Care Provider: __________________________________________ Phone: __________

Preferred Pharmacy: ___________________________________________ Phone: __________

Emergency Contact: ___________________________________________ Phone: __________

Responsible Party (Party responsible for payment): Self __ Spouse __ Parent __ Other __
Name: (Last) ___________________ (First) __________________ (Middle) ____________ Birth Date: ___________

SSN: ___________________________ Sex: Male __ Female

Address: ________________________________________________________________

City: ___________________ State: ________ Zip: __________ Country: _______________

Phone: _______________ Work: _______________ Fax: _______________ Email: __________

Primary Insurance: ____________________________________________________ Effective Date: ___________

Insured Party: Self __ Spouse __ Parent __ Other __ ID#: ___________________ Group #: __________________
Subscriber Name: (Last) ___________________ (First) __________________ Birth Date: ___________

Secondary Insurance: ____________________________________________________ Effective Date: ___________

Insured Party: Self __ Spouse __ Parent __ Other __ ID#: ___________________ Group #: __________________
Subscriber Name: (Last) ___________________ (First) __________________ Birth Date: ___________

I authorize Christiana Care Health Service to release medical information to my insurance company, its intermediaries or carrier, or another physician’s office. I hereby authorize direct payment of medical and/ or surgical benefits, to include medical benefits to which I am entitled from medicare, private insurance, and any other health plan to Christiana Care Health Services. I also permit copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing; I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

_________________________ x ________________ / / ____________ / / ____________
Signature of Patient or Legal Representative Relationship of Patient, If Legal Representative Date Time:

Interpretation: The information presented orally to the □ patient □ representative □ decision maker was interpreted into (language) ______________. The person for whom the information was interpreted stated s/he understood the interpretation.

_________________________ x __________________ / / ____________ / / ____________
Interpreter Name/ Agency ID# Staff Signature/ Title Date Time:
New Patient Form

Name: ___________________________ Date of Birth (MM/DD/YY): _______ _______ _______ Gender: _______

Provider referring you for this visit (if applicable): ___________________________ Primary Care Provider: ___________________________

Date of last gynecological visit: _______ Location/Provider: ___________________________

<table>
<thead>
<tr>
<th>Reason for Visit: ___________________________</th>
<th>Anything else you wish to discuss today: ___________________________</th>
</tr>
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</table>

Do you have an advanced directive (living will)? □ Yes □ No

Are you experiencing pain? □ Yes □ No

If yes, rate on a scale of 0-10 (0 being no pain, 10 being the worst)

Pain at rest: _____/10 Pain with activity: _____/10

Does the patient have a home care giver? □ Yes □ No □ Declined □ Unable to Verify □ N/A □ Other: ___________________________

Home Caregiver Name/Relationship: ___________________________ Home Caregiver Preferred Phone Number: (______)-_______-

LEARNING METHODS:

Do you have any Learning Barriers/Factors Affecting Learning?

- □ None at this time
- □ Acuity of Illness
- □ Cognitive deficits
- □ Cultural barrier
- □ Desire/Motivation
- □ Difficulty concentrating
- □ Emotional state
- □ Financial concerns
- □ Hearing deficit
- □ Language barrier
- □ Literacy
- □ Memory problems
- □ Other _______
- □ Vision

GYN MENSTRUAL STATUS:

Menstrual Status

Date of last menstrual period: ____________ □ Postmenopausal □ Hysterectomy

Are you currently on hormone therapy? (Please circle) Yes No

Pregnancy Prevention/Contraception: □ N/A

- □ Condom
- □ Depo Shot
- □ IUD (Intrauterine Device)
- □ Implant/Nexplanon
- □ Other _______

- □ Pills
- □ Rhythm or Withdrawal
- □ Sterilization:
  - □ Tubal ligation
  - □ Tubal occlusion
  - □ Hysterectomy
  - □ Partner vasectomy
- □ Ring
- □ Spermicide
- □ Patch

If you are menopausal, please complete section below (please circle where appropriate):

Age/year periods stopped: ______

Hysterectomy? Yes No

Hormone therapy? Yes, currently taking Yes, taken in the past Never taken

Hot Flashes? Yes No

Vaginal Dryness? Yes No

Postmenopausal bleeding? Yes No

Mood Symptoms? Yes No

Insomnia? Yes No

Bowel issues? Yes No
New Patient Form

ALLERGIES: List all drug, environment and food allergies below. □ No known allergies

<table>
<thead>
<tr>
<th>Substance</th>
<th>Type of Reaction</th>
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MEDICATIONS: List all current medications and how they are taken. INCLUDE VITAMINS and OVER THE COUNTER MEDICATIONS

□ No Current Medications

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>How often do you take it?</th>
<th>Medication Name</th>
<th>Dose</th>
<th>How often do you take it?</th>
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PREFERRED PHARMACIES

Local Pharmacy

Mail Order Pharmacy

SOCIAL HISTORY:

Alcohol Use: □ Current □ Past □ Never

What Type: □ Beer □ Wine □ Liquor □ Other: ______________________

Frequency: □ 1-2 times per year □ 1-2 times per month □ 1-2 times per week □ 3-5 times per week □ Daily

□ Several times per day □ Other: ______________________

Tobacco Use: □ Smoker, current status unknown □ Never (less than 100 lifetime)

Frequency/PPD?: □ 4 or less cigarettes (less than ½ pack)/day in last 30 days

□ Cigars or pipes daily within last 30 days

□ 5-9 cigarettes (½ - ¾ pack)/day in last 30 days

□ Cigars or pipes but not daily within last 30 days

□ 10 or more cigarettes (¾ pack or more)/day in last 30 days

□ Former smoker, quit more than 30 days ago

Tobacco Type: □ Cigarettes □ Cigars □ Oral/Chewed □ Pipe □ Vape □ Other: ______________________

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<tr>
<th>Tobacco use per day:</th>
<th>Number of years:</th>
<th>Age started:</th>
<th>Age stopped:</th>
<th>smoked in Household: □ Yes □ No</th>
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Substance Abuse: □ Current □ Past □ Never

Have you ever used street drugs with a needle? □ Yes □ No

Frequency: □ 1-2 times per year □ 1-2 times per month □ 1-2 times per week □ 3-5 times per week □ Daily

□ Several times per day □ Other: ______________________

Type: □ Amphetamines □ Hallucinogens/LSD □ Marijuana □ Other

□ Cocaine □ Heroin □ Methamphetamine □ Ecstasy □ Inhalants/Glues/Solvents □ Prescription Medications
**EXERCISE:**

- **Level:**  
  - [ ] None  
  - [ ] Occasional  
  - [ ] Moderate  
  - [ ] Vigorous  
  - [ ] Other

- **Type:**  
  - [ ] Walking  
  - [ ] Aerobics  
  - [ ] Running  
  - [ ] Swimming  
  - [ ] Weightlifting  
  - [ ] Yoga  
  - [ ] Other: [ ]

- **Times per week:**  
  - [ ] 1-2 times/week  
  - [ ] 3-4 times/week  
  - [ ] 5-6 times/week  
  - [ ] Daily  
  - [ ] Other

**FAMILY HISTORY:**  
- [ ] Unknown  
- [ ] Adopted

*Mark all that apply*

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<th>Brother</th>
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<th>Maternal Grandfather</th>
<th>Maternal Grandmother</th>
<th>Paternal Grandfather</th>
<th>Paternal Grandmother</th>
<th>Other</th>
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<td>Cancer - Ovarian</td>
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<td>Cancer - Colon</td>
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<td>Deep vein thrombosis - blood clot</td>
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<td>Pulmonary embolism (blood clot in lung)</td>
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</table>
## MEDICAL HISTORY

- Cardiovascular:  
  - High blood pressure
  - High Cholesterol
  - Heart disease/heart attack
  - Heart Failure
  - Atrial Fibrillation
  - Stroke

- Neurologic:  
  - Migraines
  - Seizures
  - TIA/Stroke

- Infectious:  
  - HIV
  - Herpes
  - Genital Warts
  - Hepatitis C
  - Hepatitis B

- Endocrine:  
  - Hypothyroidism
  - Hyperthyroidism
  - Diabetes

- Musculoskeletal:  
  - Arthritis
  - Fibromyalgia
  - Osteoporosis
  - Chronic Pain

- Renal:  
  - Kidney Stones
  - Kidney Disease

- Breast:  
  - Fibroadenoma
  - Cystic Breasts
  - Breast Pain
  - Abnormal Mammogram

- Hematology:  
  - Anemia
  - Pulmonary Embolism
  - Deep Vein Thrombosis (DVT)
  - Prior blood transfusion

- Psychiatric:  
  - Anxiety
  - Depression
  - Bipolar
  - Schizophrenia
  - ADHD
  - Suicide Attempt

- Gastrointestinal:  
  - Inflammatory Bowel Disease
  - Heart Burn/Refux
  - Gastric Bypass or Sleeve
  - Hernia

- Pulmonary:  
  - Asthma
  - COPD
  - Sleep Apnea

- Cancer:  
  - Breast
  - Cervical
  - Ovarian
  - Uterine
  - Colon
  - Skin
  - Thyroid
  - Other:

- GYN Issues:  
  - Fibroids
  - Endometriosis
  - Abnormal Pap Smears
  - Interstitial Cystitis
  - Recurrent UTIs
  - Pelvic Infections
  - Infertility
  - PMS
  - Low Libido
  - Painful Sex

## PROCEDURE AND SURGICAL HISTORY

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date/Year</th>
<th>Procedure</th>
<th>Date/Year</th>
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## SEXUAL HISTORY:

- Sexually active: Yes  No  
- More than 1 partner in the past 6 months? Yes  No  
- Age at first intercourse: __________

- Sexual preference:  
  - Male  Female  Both

- Have you been sexually assaulted or abused?  
  - Yes  No
Instructions: Please answer these questions by putting a X in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the last 3 months.

1. Do you usually experience pressure in the lower abdomen?
   □ No; □ Yes
   If yes, how much does this bother you?
   □ 1  □ 2  □ 3  □ 4
   Not at All - Somewhat - Moderately - Quite a bit

2. Do you usually experience heaviness or dullness in the pelvic area?
   □ No; □ Yes
   If yes, how much does this bother you?
   □ 1  □ 2  □ 3  □ 4
   Not at All - Somewhat - Moderately - Quite a bit

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?
   □ No; □ Yes
   If yes, how much does this bother you?
   □ 1  □ 2  □ 3  □ 4
   Not at All - Somewhat - Moderately - Quite a bit

4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?
   □ No; □ Yes
   If yes, how much does this bother you?
   □ 1  □ 2  □ 3  □ 4
   Not at All - Somewhat - Moderately - Quite a bit

5. Do you usually experience a feeling of incomplete bladder emptying?
   □ No; □ Yes
   If yes, how much does this bother you?
   □ 1  □ 2  □ 3  □ 4
   Not at All - Somewhat - Moderately - Quite a bit
6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?
   If yes, how much does this bother you?
   □ 1 □ 2 □ 3 □ 4
   Not at All - Somewhat - Moderately - Quite a bit

7. Do you feel you need to strain too hard to have a bowel movement?
   If yes, how much does this bother you?
   □ 1 □ 2 □ 3 □ 4
   Not at All - Somewhat - Moderately - Quite a bit

8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?
   If yes, how much does this bother you?
   □ 1 □ 2 □ 3 □ 4
   Not at All - Somewhat - Moderately - Quite a bit

9. Do you usually lose stool beyond your control if your stool is well formed?
   If yes, how much does this bother you?
   □ 1 □ 2 □ 3 □ 4
   Not at All - Somewhat - Moderately - Quite a bit

10. Do you usually lose stool beyond your control if your stool is loose or liquid?
    If yes, how much does this bother you?
    □ 1 □ 2 □ 3 □ 4
    Not at All - Somewhat - Moderately - Quite a bit

11. Do you usually lose gas from the rectum beyond your control?
    If yes, how much does this bother you?
    □ 1 □ 2 □ 3 □ 4
    Not at All - Somewhat - Moderately - Quite a bit
12. Do you usually have pain when you pass your stool?

If yes, how much does this bother you?

☐ 1  ☐ 2  ☐ 3  ☐ 4  
Not at All - Somewhat - Moderately - Quite a bit

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?

If yes, how much does this bother you?

☐ 1  ☐ 2  ☐ 3  ☐ 4  
Not at All - Somewhat - Moderately - Quite a bit

14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?

If yes, how much does this bother you?

☐ 1  ☐ 2  ☐ 3  ☐ 4  
Not at All - Somewhat - Moderately - Quite a bit

15. Do you usually experience frequent urination?

If yes, how much does this bother you?

☐ 1  ☐ 2  ☐ 3  ☐ 4  
Not at All - Somewhat - Moderately - Quite a bit

16. Do you usually experience urine leakage associated with a feeling of urgency, that is a strong sensation of needing to go to the bathroom?

If yes, how much does this bother you?

☐ 1  ☐ 2  ☐ 3  ☐ 4  
Not at All - Somewhat - Moderately - Quite a bit

17. Do you usually experience urine leakage related to coughing, sneezing, or laughing?

If yes, how much does this bother you?

☐ 1  ☐ 2  ☐ 3  ☐ 4  
Not at All - Somewhat - Moderately - Quite a bit
18. Do you usually experience small amounts of urine leakage (that is, drops)?
   If yes, how much does this bother you?
   □ 1 □ 2 □ 3 □ 4
   Not at All - Somewhat - Moderately - Quite a bit

   □ No; □ Yes

19. Do you usually experience difficulty emptying your bladder?
   If yes, how much does this bother you?
   □ 1 □ 2 □ 3 □ 4
   Not at All - Somewhat - Moderately - Quite a bit

   □ No; □ Yes

20. Do you usually experience pain or discomfort in the lower abdomen or genital region?
   If yes, how much does this bother you?
   □ 1 □ 2 □ 3 □ 4
   Not at All - Somewhat - Moderately - Quite a bit

   □ No; □ Yes
**Instructions:**

1. Pick three days and keep track of how many times you void and when you leak.
2. Every time that you void, put a "V" in the hour that corresponds when you void.
3. If you leak, put an "L" in the hour that corresponds to when you leak. If you leak more than once in that hour please place more "L’s" below that hour.
4. Each line represents a 24-hour period

**Day 1 Date:**

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**Day 2 Date:**

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**Day 3 Date:**

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Please answer the following 2 questions.

1. How often do you experience urinary leakage? (Please check one)
   - Never, I do not leak urine (0)
   - Less than once a month (1)
   - A few times a month (2)
   - A few times a week (3)
   - Every day and/or night (4)

2. How much urine do you lose each time? (Please check one)
   - None, I do not leak urine (0)
   - Drops (1)
   - Small Splashes (2)
   - More (3)

Thank you for answering these questions.

Score is calculated by multiplying score from question one with score from question 2
ISI score _______
ISI category (circle):
None     Slight (1-2)  Moderate (3-6)  Severe (8-9)  Very severe (12)
Center for Urogynecology and Pelvic Surgery

Current Medication List

Pt Name: 
Date of Birth: 
Today’s Date: 

<table>
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<tr>
<th>MEDICATION</th>
<th>STRENGTH &amp; AMOUNT YOU TAKE</th>
<th>HOW OFTEN</th>
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Signature of Patient or Legal Representative
Date: __/___/__________

Relationship to Patient, if Legal Representative
Time: ___________________
**Center for Urogynecology and Pelvic Surgery**

*Please complete this form if you have concerns about your sexual health that you would like to discuss with your provider*  

---

**Decreased Sexual Desire Screener (DSDS)**

Date: ___/___/___

Name: ___________________________  DOB: ___/___/___  Age: ______

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<tr>
<td>1. In the past, was your level of sexual desire or interest good and satisfying to you?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>2. Has there been a decrease in your level of sexual desire or interest?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3. Are you bothered by your decreased level of sexual desire or interest?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Would you like your level of sexual desire or interest to increase?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5. Please circle all the factors that you feel may be contributing to your current decrease in sexual desire or interest:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. An operation, depression, injuries, or other medical condition</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>B. Medications, drugs, or alcohol you are currently taking</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>C. Pregnancy, recent childbirth, menopausal symptoms</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>D. Other sexual issues you may be having (pain, decreased arousal or orgasm)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>E. Your partner's sexual problems</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>F. Dissatisfaction with your relationship or partner</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>G. Stress or fatigue</td>
<td>Yes</td>
</tr>
</tbody>
</table>

When completed, please give this form back to your health care provider.