BELLA
WELLNESS & AESTHETICS

Females Only Intake Questionnaire

Are you **sexually active**? ☐ Yes ☐ No

Do you have **pain** with intercourse? ☐ Yes ☐ No

What type of **contraception** are you using (please check all that apply)?
☐ None ☐ Pills ☐ IUD ☐ Foam ☐ Condoms ☐ Tubal Ligation
☐ Diaphragm ☐ Hysterectomy ☐ Partner Vasectomy ☐ Withdrawal ☐ Depo-Provera
☐ Implants ☐ Other: _____

Are you having any problems with your method of **birth control**? ☐ Yes ☐ No

Have you ever had any vaginal, cervical and/or tubal **infection**? ☐ Yes ☐ No
If yes, please check all that apply:
☐ Gardnerella ☐ Syphilis ☐ Condyloma ☐ Bacterial Vaginitis ☐ Yeast ☐ PID
☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ Warts ☐ Other: _____

Date of last **PAP** smear _____ ☐ Normal ☐ Abnormal
If abnormal, how was it treated (please check all that apply)?
☐ Repeated Pap Smear ☐ Colposcopy ☐ Laser Surgery ☐ Cone Biopsy
☐ Cryosurgery (freezing) ☐ Hysterectomy ☐ Loop Excision

Date of last **Mammogram**: _____ ☐ Normal ☐ Abnormal
If abnormal, how was it treated (please check all that apply)?
☐ Repeat Mammogram ☐ Breast Ultrasound ☐ Needle Biopsy ☐ Mastectomy
☐ Lumpectomy ☐ Other: _____

Do you have **breast** lumps, tenderness or discharge? ☐ Yes ☐ No

Do you do **self-breast exams**? ☐ Yes ☐ No

Do you have **PMS** symptoms? ☐ Yes ☐ No

Do you have **fibroids** of the uterus? ☐ Yes ☐ No

Have you had **abnormal bleeding** in the past? ☐ Yes ☐ No

Have you ever had or currently have the following type(s) of **cancer**?
☐ Ovarian ☐ Cervical ☐ Uterine ☐ Endometrial ☐ Vaginal
If yes, what type of treatment did you receive? _____

Have you had or currently have difficulty getting **pregnant**? ☐ Yes ☐ No

Have you had or are currently trying the following **infertility** treatments? ☐ Yes ☐ No
☐ Timed intercourse ☐ Medications – type? _____ ☐ IVF
☐ Artificial insemination ☐ Ovulation induction ☐ Assisted reproductive technology
☐ Counseling

Are you still having your **periods**? ☐ Yes ☐ No

If no, please check reason:

☐ Ablation ☐ Menopause ☐ Contraception ☐ Hysterectomy

If you had a Hysterectomy, do you have a uterus? ☐ Yes ☐ No

If yes, are your periods **regular**? ☐ Yes ☐ No

Does **bleeding** occur between your normal period cycle? ☐ Yes ☐ No

Do you suffer from **cramps** during your periods? ☐ Yes ☐ No

If yes, please check the pain associated with the cramps:

☐ Mild ☐ Moderate ☐ Severe

What treatment, if any are you using for your cramps? _____

First day of your last **period**: _____