Concorde Women's Health

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Name:______________________________________ **Date**:________________________

Are you allergic to Latex?: Yes No
Please list any **new drug allergies, medical conditions or surgeries** since your last visit**:**

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Patient Symptom Questionnaire

Please check the correct choice regarding your symptoms **for the past week**.
SYMPTOM SCORES: 0- NONE 1- RARE 2- SOME 3- QUITE A BIT 4- SEVERE

Symptom					
1) Nausea	**0**	**1**	**2**	**3**	**4**
2) Vomiting	**0**	**1**	**2**	**3**	**4**
3) Diarrhea	**0**	**1**	**2**	**3**	**4**
4) Constipation	**0**	**1**	**2**	**3**	**4**
5) Loss of appetite	**0**	**1**	**2**	**3**	**4**
6) Dryness of mouth	**0**	**1**	**2**	**3**	**4**
7) Dizziness	**0**	**1**	**2**	**3**	**4**
8) Weakness	**0**	**1**	**2**	**3**	**4**
9) Change of vision	**0**	**1**	**2**	**3**	**4**
10) Sleepiness	**0**	**1**	**2**	**3**	**4**
11) Sleeplessness	**0**	**1**	**2**	**3**	**4**
12) Palpitations	**0**	**1**	**2**	**3**	**4**
13) Hot flashes	**0**	**1**	**2**	**3**	**4**
14) Nervousness / Tension	**0**	**1**	**2**	**3**	**4**
15) Depression	**0**	**1**	**2**	**3**	**4**
16) Headaches	**0**	**1**	**2**	**3**	**4**
17) Backaches	**0**	**1**	**2**	**3**	**4**
18) Lower abdominal pressure	**0**	**1**	**2**	**3**	**4**
19) Lower abdominal pain	**0**	**1**	**2**	**3**	**4**
20) Painful intercourse	**0**	**1**	**2**	**3**	**4**
21) Vaginal pressure	**0**	**1**	**2**	**3**	**4**
22) Vaginal discharge	**0**	**1**	**2**	**3**	**4**
23) Vaginal discomfort/itching	**0**	**1**	**2**	**3**	**4**
24) Uncomfortable strong need to pass urine	**0**	**1**	**2**	**3**	**4**
25) Burning when passing urine	**0**	**1**	**2**	**3**	**4**
26) Loss of urine when coughing or straining	**0**	**1**	**2**	**3**	**4**
27) Loss of urine before reaching toilet	**0**	**1**	**2**	**3**	**4**
28) Involuntary loss of stool	**0**	**1**	**2**	**3**	**4**
29) Involuntary loss of gas	**0**	**1**	**2**	**3**	**4**

30) Indicate number of hours between times you pass urine __________

31) Indicate number of times you void at night after going to sleep __________

Physician's Review (Initial) __________