Patient Prescription Form

NAME:_____

Medication Name	Dosage	Usage (1 pill a day, 3 pills a day)

INTIMMEDICINE SPECIALISTS

PATIENT INFORMATION:	Appt. Date:	Appt. Time	Today's Date:	Date of Birth:

Patient Name:	Marital Status:	Phone Message: Yes Cell # Work #

Address:	Email:

Primary Physician: Name: Address: Phone: Fax:	Referring Physician: Name: Address: Phone: Fax:

PRIMARY INSURANCE INFORMATION

Insurance Company:	ID#	Group #
Address:	Phone #	
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder Phone #
Policy Holder's Employer:	Relation to Ins:	Insurance Effective date:

SECONDARY INSURANCE INFORMATION

Insurance Company:	ID#	Group #
Address:	Phone #	
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder Phone #
Policy Holder's Employer:	Relation to Ins:	Insurance Effective date:

Authorized Person to contact for billing or results

Name:	Phone:		Phone:

1. Financial Responsibility

I certify that the information I have provided regarding my insurance coverage is correct and authorize James A Simon MD PC. to verify insurance coverage and benefits allowed in accordance -with my insurance plan's policies

I authorize that payments be made directly to James A Simon MD for all medical insurance benefits which are payable under the terms of my insurance policy for the services provided.
I agree to pay any copayments, coinsurance, or deductible as required by my insurance plan for medical care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan.
I agree to accept full responsibility for payment if my insurance coverage is not verified.

2. Release of Medical Information For Billing

I hereby authorize James A Simon MD PC to submit a claim to my insurance company, health .and welfare fund, Medicare or Medicaid for medical services provided to me or my dependent.

I also authorize James A Simon MD PC provide a copy of this release and a copy of medical records related to such services if requested by the payer. Further, I authorize James A Simon MD PC to release medical information to my consulting or primary care physician to assist with continuity of my health care. This release will expire one year from the date of my signature below unless I cancel this release in writing prior to that date.

3. Non-Covered Services

I agree to pay for medical services provided to me or my dependent which are not covered by the benefits in my insurance plan.

I Agree to the Above stated responsibility and consent

Name:	Signature:	Date:

James A. Simon, MD, PC - Rachel S. Rubin, MD
1850 M Street NW, Washington DC 20036

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATIN ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This notice takes effect April 14, 2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for the treatment, payment, and healthcare operations (TPO):
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use or disclose your health information to obtain payment for services we provide for you.
Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Computers are located throughout our practice. Schedules and the patient's proposed treatment are posted on the computer throughout our facility to achieve communication and high quality healthcare.
Your Authorization: In addition to our use of your information for TPO, you may give us written authorization to use your health information or to disclose it for other purposes. If you give us an authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family & Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, than prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.
Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization. We may forward a regular newsletter to our patients and prospective new patients which describe the various services available from our practice.
Required By Law: We may use or disclose your health information when we are required to do so by law. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text message, letters or e-mail.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information.)
We will charge you a reasonable cost-based fee for expenses such as copies and staff time.
Disclosure Accounting: you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than TPO, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information.
We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Questions & Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PATIENT OR LEGAL GUARDIAN SIGNATURE

Signature

_____**Date**_____

IntimMedicine Specialists
1850 M Street, NW #450
Washington DC 20036

E-Prescription Consent

- **Formulary and benefit transactions**- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification**- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.
-

By signing this consent form you are agreeing that James A. Simon, M.D., P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. Understanding all the above, I herby provide informed consent to James A.Simon, M.D., P.C. To enroll me in the ePrescribe program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

SIGNATURE_____**DATE**_____

PRINT NAME_____

DATE OF BIRTH_____

E-MAIL:_____

NAME/ADDRESS/ PHONE NUMBER OF PHARMACY:

_____

Appointment Date: _____

Appointment Time: _____

IntimMedicine Specialists

Patient Questionnaire

Name: _____ Date of Birth: _____ Age: _____

Occupation: _____ Marital Status: _____

Referred by: _____

Address of Referring Physician(s): _____

_____

Allergies: _____

_____

Medications Currently Taking: _____

_____

_____

Reason for today's appointment: (Please check the appropriate statements below)

- ☐ Routine exam - no problems
- ☐ Bleeding between periods
- ☐ Stopped having periods
- ☐ Never had periods
- ☐ Premenstrual discomfort
- ☐ Contraception
- ☐ Previous miscarriage(s)
- ☐ Breast problems
- ☐ Second opinion
- ☐ Irregular periods
- ☐ Light periods
- ☐ Menopause
- ☐ Pelvic pain or cramps
- ☐ Cannot get pregnant
- ☐ Vaginal infection
- ☐ Bone density
- ☐ Overweight
- ☐ Underweight
- ☐ Heavy periods
- ☐ Hormone therapy
- ☐ Excess hair growth
- ☐ Reverse tubal operation
- ☐ Bladder infection
- ☐ Osteoporosis

Any other gynecologic problems or concerns you wish to address today: _____

_____

_____

_____

_____

_____

Please answer the following questions by filling in the blank or by checking "Yes" if it is the appropriate response.

Menstrual History

Age at first menstrual-period	_____	Do You Have:	**YES**
Starting date of last period	_____	Heavy bleeding	_____
Starting date of period before that one	_____	Bleeding between periods	_____
		Pain with periods	_____
Usual # of days from start of one period to the next	_____	Premenstrual symptoms (bloating, breast soreness, fatigue, irritability)	_____
Bleeding lasts (# of days)	_____		
Age at menopause, if applic.	_____		

Gynecologic History

YES

Date of last pelvic exam: _____
Date of last pap smear: _____; was it abnormal? _____
Have you ever had an abnormal pap smear _____
Date of last mammogram: _____; was it abnormal? _____
Do you have hair growth you consider abnormal? _____
If yes, did you receive treatment? _____
Do you have discharge from your breasts? _____
Have you ever had a tubal infection? _____
If yes, were you treated with antibiotics? _____
History of venereal disease (gonorrhea, syphilis, herpes, chlamydia, etc.)? If so, specify_____ _____
Did your mother take diethyltilbestrol while pregnant with you? _____

Sexual History

Are you sexually active? _____
Frequency of sexual intercourse per week_____
Is intercourse painful? _____
Have you ever been treated for the pain? _____
If yes, describe_____
Do you have any sexual questions or concerns you would like to discuss? _____

_____
_____
_____

Contraceptive History

YES

Are you using a form of birth control? _____
If so, please list:_____
Have you ever used:
Birth control pills: _____
Which types and dates used_____
_____
IUD (intrauterine device) _____
Type_____ Dates used_____
Problems (please list)_____
Diaphragm _____
Condom _____
Other: _____ _____

Obstetrical History

How many times have you been pregnant?_____
If applicable, please describe below:

Premature Births:_____ Miscarriages:_____ Abortions: ___ Living Children:_____

Date	Weeks Preg	Vaginal	(Check appropriate section) C-sect	Miscar	Abort	Complications

Surgical History

Please describe any previous pelvic or abdominal surgery (on the uterus, ovaries, tubes, cervix, or intestines including laparoscopies or appendectomy)

Type of Surgery Year Reason or Diagnosis Complications

List any other surgery:_____

Medical History

Do you have a history of:

- ☐ Emotional Problems
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Infections
- ☐ Bowel Problems
- ☐ Liver Problems
- ☐ Lung Disease
- ☐ Chronic Cough
- ☐ Visual Disturbances
- ☐ Rheumatic Fever
- ☐ Anorexia, Bulimia
- ☐ Ulcers or Stomach Problems
- ☐ Gall Bladder Disease
- ☐ Stroke
- ☐ Kidney Stones
- ☐ Bladder Infections
- ☐ Hepatitis or Jaundice
- ☐ Lung Disease
- ☐ Sinus Problems
- ☐ Difficulty Swallowing
- ☐ Skin Problems, Acne
- ☐ Other:_____
- ☐ Arthritis
- ☐ Easy Bruising
- ☐ Heart Murmur
- ☐ Loss of Urine
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Seizure Disorders
- ☐ Hearing Problems
- ☐ Cancer

Please list treatments prescribed for items above:_____

Family History

YES

Indicate your ethnic background (i.e. African American, Mediterranean, Eastern European Jewish):_____

Does anyone in your family have a genetic disorder (i.e., cystic fibrosis. sickle cell anemia, Tay-Sachs. thalassemia)? _____
If so, how are they related to you?:_____

Does anyone in your family have mental retardation? _____
If so, how are they related to you?:_____

Does anyone in your family have a birth defect (i.e.. clubfoot, cleft lip and/or palate)? _____
If so, how are they related to you?:_____

Does anyone in your family have a chromosome abnormality (i.e. Down Syndrome, or Mongolism)? _____
If so, how are they related to you?:_____

Is there a family medical history of cancer? _____
If so, what relative and what kind of cancer_____
_____

Is there a family medical history of diabetes? _____

Please list any other medical problems which seem to run in your family or are of concern to you:

_____
_____

Social History

YES

Have you had previous marriages? If so, how many?_____ _____

Have you ever lived or traveled outside of the U.S.?
If so, where?_____

Do you smoke cigarettes now? If yes, how many packs/week?_____ _____
Have you smoked before and stopped? _____
How many years have you smoked in total?_____

Do you drink alcohol? If so, how many glasses/week?_____ _____

Do you use recreational drugs? _____
If so. specify_____

Have you ever worked with toxic chemicals, heavy metals or ionizing radiation? If so, specify_____ _____

How many hours do you exercise each week?_____

Which sports you participate in:_____
_____
_____

Family History Questionnaire

Patient Name: _____ Physician Seeing Today: _____
Date of Birth: _____ Age: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please consider these family members when completing:
1st Degree Relatives = Mother / Father / Sister / Brother / Children
AND 2nd Degree Relatives = Aunt / Uncle / Grandparent / Niece / Nephew

Have you or any of your relatives had cancer genetic testing? ☐ **YES** ☐ **NO** Explain: _____

Yes/No		**BREAST / OVARIAN CANCER** (HBOC/BRAC Analysis)	SELF SIBLINGS CHILDREN	MOTHER'S SIDE	FATHER'S SIDE	Age of Diagnosis
Y	N	***EXAMPLE: Breast cancer diagnosed before age 50***		***Mother***		***47***
◯	◯	**Breast cancer diagnosed before age 50**				
◯	◯	**Ovarian cancer** at any age				
◯	◯	**THREE relatives** on the same side of the family with **breast cancer at any age** (please also include 3rd degree relatives: cousins and great relatives)				
◯	◯	**Multiple breast cancers** in the same person (in the same breast or in both breasts)				
◯	◯	**Male breast cancer** at any age				
◯	◯	**Ashkenazi Jewish ancestry** with a breast, ovarian or pancreatic cancer in the family at any age				

Yes/No		**COLON / UTERINE CANCER** (Lynch Syndrome/Colaris)	SELF SIBLINGS CHILDREN	MOTHER'S SIDE	FATHER'S SIDE	Age of Diagnosis
◯	◯	Have **YOU** been diagnosed with **colon** or **uterine** (endometrial) cancer or **before age 50**				
◯	◯	**TWO or more relatives** on the same side of the family w/ any of the following, **one diagnosed before age 50**: *Colon, Uterine/Endometrial, Ovarian, Stomach*				
◯	◯	**THREE or more relatives** on the same side of the family w/ any of the following, diagnosed **at any age**: *Colon, Uterine/Endometrial, Ovarian, Stomach*				

Any other cancer in you or any family members? (*Ex: Prostate, Pancreatic, Melanoma, >10 colon polyps, Brain, Sebaceous Adenomas, etc.):*
Please list RELATIVE, CANCER SITE and AGE of diagnosis:

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☐ Patient **is** appropriate for hereditary cancer genetic testing ☐ Patient **not** appropriate
☐ Patient counseled/offered hereditary cancer genetic testing: ☐ ACCEPTED or ☐ DECLINED

HCP Signature: _____ **Patient Signature:** _____

VULVODYNIA QUESTIONNAIRE

Please complete this form and give it directly to the doctor.

REFERRING DOCTOR'S NAME _____

ADDRESS _____

_____

Today's date _____ _____

NAME _____ City, State _____

Age, Date of birth _____ Marital status_____

MEDICAL HISTORY

Number of pregnancies _____ Number of children (age of youngest) _____

Last menstrual period (date) _____

Methods of birth control used in past (give dates) _____

_____

Present method of birth control_____

Gynecology problems, procedures, or surgeries? □ NO □YES (If yes, please give dates)

☐Hysterectomy If yes, reason _____

☐Abnormal Pap smear If yes, ☐once only ☐treated with cryo

☐Laser of cervix If yes, ☐for HPV (warts)☐for dysplasia or cancer

☐Laser of vulva (CO_2 laser) ☐for HPV (warts)☐for dysplasia or cancer

Other (use back of page if necessary, but only after completing entire questionnaire)

_____

_____

Urological problems, procedures, or surgeries? □NO □ YES

If yes, please describe _____

_____

Back problems (injury, slipped disc, sciatica, surgery, other)? □NO □ YES

If yes, please describe _____

_____

Other hospitalizations (besides childbirth or those listed above)? □NO □ YES

If yes, please state year, illness, or surgery:

_____

_____

Other health problems: _____

_____

Do you take any of the following tablets or medicines? Please give medication names.

Steroids (cortisone) □NO □ YES _____

Aspirin or pain killers □NO □ YES _____

Sedatives or tranquilizers □NO □ YES _____

Laxatives (for constipation) □NO □ YES _____

Hormones (including contraceptive pill) □NO □ YES _____

Antibiotics □NO □ YES _____

Other pills, medicine, or drugs taken regularly? □NO □ YES If yes, please give exact names:

_____

_____

Are you allergic to or have you had any bad reactions to any drugs? □ NO □ YES

If yes, which ones? What happened?

_____

SKIN

Does your skin react against or are you allergic to any other substances?
(i.e. Elastoplast, tape, metal, make-up, or jewelry) □ NO □ YES If yes, what?

_____

Indicate your skin coloring and type:	Natural hair color	Eye color
□ very fair (always burn, never tan)	□ Blonde	□ Blue
□ fair (usually burn, tan with difficulty)	□ Red	□ Green
□ average (sometimes burn, tan average)	□ Brown	□ Hazel
□ dark (rarely burn, tan easily)	□ Black	□ Brown
□ Black	□ Grey	□ Black

Would you describe your skin as "sensitive?" □ NO □ YES If yes, why?

_____

_____

Do you see a dermatologist regularly? □ NO □ YES If yes, what is your treatment?

_____

GENERAL

What is your present work or occupation? _____
What types of work have you done in the past _____
Any special hobbies? □ NO □ YES If yes, what? _____
Do you do any physical fitness activities? □ NO □ YES
If yes, what? How often? _____
Do you smoke tobacco? □ NO □ YES If yes, how much each day _____
Do you drink alcohol? □ NO □ YES If yes, how much each week _____
Drink sugar-free sodas? □ NO □ YES If yes, how many each day _____
Use sugar substitutes □ NO □ YES If yes, what % of the time _____
Do you eat any special foods or stay on a certain diet? □ NO □ YES
If yes, what things are included or excluded? _____

_____

_____

Do you regularly take any food supplements or vitamins? □ NO □ YES
If yes, what? _____

_____

PRESENT PROBLEM

In your own words, describe the symptoms (discomfort) you are having

_____

_____

What bothers you the most about your problem? _____

_____

Have you been free of symptoms at any time? □ NO □ YES
If yes, when? _____

_____

What seems to make it worse? _____

_____

What can you do to get relief? _____

_____

When did you first begin having discomfort?

- ☐ less than 6 months ago
- ☐ 6 months to 1 year ago
- ☐ 1 to 3 years ago
- ☐ 5 to 10 years ago
- ☐ more than 10 years ago

How are the symptoms you now have related to your INITIAL symptoms?

- ☐ same
- ☐ less intense discomfort
- ☐ more intense discomfort
- ☐ less frequent
- ☐ more frequent

Are there certain times of the day when your symptoms are more noticeable?
(indicate as many as apply)

- ☐ always the same throughout the day
- ☐ morning
- ☐ evening
- ☐ night (bedtime)
- ☐ with urination

Are there certain times of the month when your symptoms are more noticeable?

- ☐ always the same during the month
- ☐ worse just before my menstrual cycle
- ☐ worse during my menstrual cycle
- ☐ worse after my menstrual cycle
- ☐ worse when I ovulate (mid-cycle)

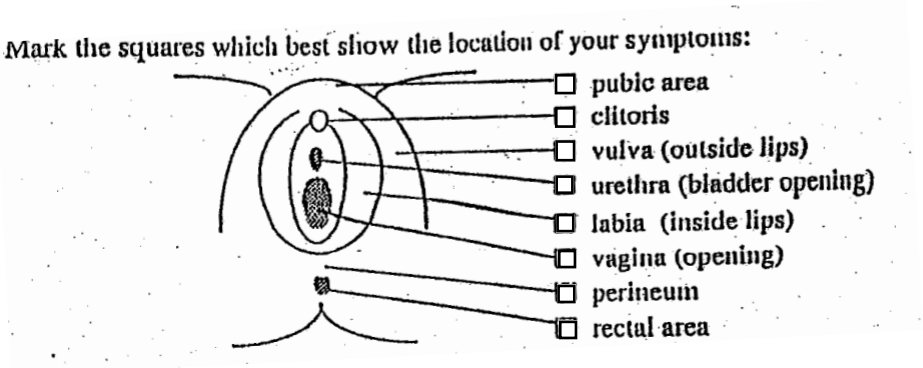
With regard to the urinary tract and bladder, do you have any of the following problems?

- ☐ have to urinate more than 5 times in 12 hours
- ☐ get up more than twice at night to urinate
- ☐ frequent urinary tract infections
- ☐ difficulty voiding
- ☐ bladder pain which improves after voiding

During my menstrual period:

- ☐ I use a sanitary pad exclusively
- ☐ I use tampons exclusively
- ☐ I use tampons and/or pads depending on flow
- ☐ Sanitary pads make my discomfort worse
- ☐ Tampons make my discomfort worse
- ☐ I do not menstruate

Mark the squares which best show the location of your symptoms:



My feelings of discomfort can best be described as:

- ☐ diffuse (over the whole vulvar area)
- ☐ localized (in one or more specific small spots)
- ☐ pulsating (throbbing)
- ☐ deep, steady ache
- ☐ predominantly on one side
- ☐ itching
- ☐ burning
- ☐ other (describe) _____

Are bouts of discomfort essentially alike? ☐ NO ☐ YES

If no, how do they differ?

- ☐ kind of discomfort (eg constant aching vs throbbing)
- ☐ location of pain
- ☐ associated symptoms
- ☐ intensity of discomfort
- ☐ other (describe) _____

The statement which describes the discomfort which I most often have:

- ☐ slight, I notice only when I think about it
- ☐ slight, I can ignore it by not thinking about it
- ☐ moderate, I always know it's there but I can still perform most tasks
- ☐ severe, it allows me to perform only tasks which require little concentration
- ☐ severe, makes it impossible for me to do anything but seek medical attention

On a scale from 0 to 100, where 0 represents no discomfort at all and 100 represents the most pain you could possibly stand, what value would you assign to:

Your worst symptoms _____

Your usual symptoms _____

My discomfort usually causes:

- ☐ NO interference with daily routine or planned activities
- ☐ SOME interference with daily routine or planned activities
- ☐ an interruption in daily routine or planned activities
- ☐ confinement to bed
- ☐ the pursuit of immediate medial attention

My symptoms:

- ☐ do not affect sexual intercourse
- ☐ sometimes prevent sexual intercourse

- ☐ completely prevent sexual intercourse
- ☐ cause discomfort, but do not prevent sexual intercourse
- ☐ don't know – I am not sexually active (skip the next two questions)

If I try to have intercourse, my discomfort is: (indicate as many as apply)

- ☐ not a problem
- ☐ worse with certain positions
- ☐ mostly at the opening of the vagina (entry is painful)
- ☐ painful at entry, then intercourse is tolerable
- ☐ mostly irritated afterward for an hour or so
- ☐ mostly irritated afterward for a day or so

With regard to sexual activity and foreplay:

- ☐ I am easiy aroused, and have good natural vaginal lubrication
- ☐ I get aroused, but vaginal dryness is often a problem
- ☐ sexual arousal makes my vaginal symptoms worse
- ☐ arousal feels good, but intercourse is painful
- ☐ I have a hard time getting sexually aroused

With regard to sexual activity IN THE PAST: (indicate as many as apply)

- ☐ I used to enjoy sexual intercourse
- ☐ intercourse has always been somewhat uncomfortable
- ☐ I have been forced to have intercourse against my will (one or more times)
- ☐ I had unpleasant sexual experience(s) in my childhood
- ☐ I think my past experience(s) may have caused some of the problems I have now
- ☐ I think my past sexual activity would be considered pretty normal
- ☐ other (comment) _____

_____

When/if my symptoms prevent sexual intercourse, my partner and I:

- ☐ avoid sexual intimacy altogether
- ☐ are physically close, but avoid sexual arousal
- ☐ concentrate on my partner's satisfaction
- ☐ have relations as usual

Have you used lubricants during intercourse? ☐ NO ☐ YES

If yes, please give name(s). Any problems?

_____

Is your partner aware of your problem? ☐ NO ☐ YES

If yes, what is the reaction?

_____

Indicate the effect each of the following has on your discomfort:

	RELIEF	NO CHANGE	WORSENS
Heat (like a warm bath)	☐	☐	☐
Cold (like a cool compress)	☐	☐	☐
Sexual activity	☐	☐	☐
Friction (rubbing or scratching)	☐	☐	☐
Urination	☐	☐	☐
Other significant activity (describe)			
_____	☐	☐	☐
_____	☐	☐	☐

Have you been to another physician for this problem? □ NO □ YES

If yes, please indicate his/her specialty:

- □ Family practicioner
- □ Internist (general medicine)
- □ Gynecologist (if more than one, how many? _____)
- □ Urologist (if more than one, how many? _____)
- □ Dermatologist (if more than one, how many? _____)
- □ other (indicate) _____

Have you been treated for any of the following conditions in relation to your present problem?

- □ Yeast infections
- □ Urinary tract infections
- □ Herpes
- □ Venereal warts (condylomata, HPV)
- □ Lichen sclerosus
- □ Interstitial cystitis
- □ Vaginitis
- □ Atrophic vaginitis
- □ other (indicate what kind, or put "DK" if you don't know)