MONA LISA PATIENT MEDICAL HISTORY FORMS

NAME

DOB

Last menstrual period date

Number of pregnancies/deliveries

Number of Vaginal Deliveries Number of Cesarean Sections

Gynecologic Surgeries

Breast Surgeries

Radiation Therapy – to what body part?

Do you have any mesh in the vaginal or rectal area?

Do you make keloids (abnormally thick scars)?

How long has sex been uncomfortable?

What have you tried that has helped or not helped?

Are you using estrogen therapy – oral, transdermal or vaginal?

If yes, what type and for how long?

When was your last pap smear?

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Please list all medications you are on now

SIGNATURE:

DATE:

If you would like a treatment summary sent to your physician, please list name and address below.

THANK YOU FOR ALLOWING US TO SERVE YOU.