NEW YORK GYNECOLOGY SURGERY & ENDOMETRIOSIS

Endometriosis Questionnaire

For patients presenting for an endometriosis consultation

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Patient name _____ **Date** _____

Date of birth _____ **Referring doctor** _____

Please complete this form before your visit. Answer as best you can - an approximate answer is more helpful than a blank. Check every box that applies. If a question does not apply to you, leave it blank.

PART A | YOUR ENDOMETRIOSIS HISTORY

1. YOUR DIAGNOSIS AND GOALS

Have you ever been diagnosed with endometriosis? ☐ Yes - by surgery / biopsy ☐ Yes - by imaging (MRI / ultrasound) ☐ Suspected from symptoms only ☐ Not yet

Age symptoms began _____ **Age endo first suspected** _____ **Age diagnosed** _____

In your own words, what is your main concern today? _____

Would you consider a hysterectomy if it were recommended? ☐ Yes ☐ No ☐ Unsure

What matters most to you? (check all that apply) ☐ Pain relief ☐ Getting a diagnosis / answers ☐ Becoming pregnant ☐ Keeping my uterus ☐ Keeping my ovaries ☐ A long-term / definitive solution

2. MENSTRUAL HISTORY

Age at first period _____ **Days of bleeding** _____ **Age period pain began** _____

Do you still have periods? ☐ Yes ☐ No - hysterectomy ☐ No - menopause ☐ No - due to medication

Cycle: ☐ Regular (every 21-35 days) ☐ Irregular

Flow: ☐ Light ☐ Medium ☐ Heavy

	Yes	No		Yes	No
Soak a pad/tampon in under 2 hours	☐	☐	Bleeding with intercourse	☐	☐
Pass clots larger than a quarter	☐	☐	Ever told you were anemic	☐	☐
Brown spotting before period starts	☐	☐	Ever had iron infusion or transfusion	☐	☐
Bleeding between periods	☐	☐	Abnormal Pap smear ever	☐	☐

First day of last period _____ **Date of last Pap smear / result** _____

Prior infections (check any): ☐ PID ☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ Genital warts ☐ None

Could you be pregnant now? ☐ Yes ☐ No ☐ Not sure

3. PREGNANCY AND FERTILITY

Pregnancies	Vaginal births	C-sections	Miscarriages	Ectopic	Terminations

Are you trying to become pregnant now? ☐ Yes ☐ No **If yes, for how long:** _____

Do you want a pregnancy in the future? ☐ Yes ☐ No ☐ Unsure

Fertility treatment: ☐ None ☐ Clomid / letrozole ☐ IUI ☐ IVF ☐ Egg freezing **Number of cycles:** _____

AMH level, if known _____ **Fertility clinic / doctor** _____

Tube test (HSG) result: ☐ Both tubes open ☐ One tube blocked ☐ Both blocked ☐ Not done / unsure

Partner semen analysis: ☐ Normal ☐ Abnormal ☐ Not done ☐ Not applicable

Frozen eggs or embryos? ☐ None ☐ Eggs ☐ Embryos **How many:** _____

Pregnancy complications: ☐ None ☐ Placenta previa ☐ Placenta accreta ☐ Preterm birth ☐ Heavy bleeding after delivery ☐ Preeclampsia ☐ Gestational diabetes

Are you breastfeeding now? ☐ Yes ☐ No

Current contraception: ☐ None ☐ Pill / patch / ring ☐ IUD ☐ Implant ☐ Condoms ☐ Partner vasectomy ☐ Tubal ligation ☐ Not sexually active

4. PAIN SCORES

Rate each type of pain at its WORST over the past 3 months. 0 = no pain, 10 = worst pain imaginable. Write N/A if it does not apply.

Type of pain	0-10	Type of pain	0-10
Pain with periods		Pain with bowel movements	
Deep pain during intercourse		Pain with urination	
Pain at entry with intercourse		Mid-cycle (ovulation) pain	
Pain lasting hours after intercourse		Pelvic pain on non-period days	
Average pain over the past month		Pain right now	

Where is your pain? (check all that apply) ☐ Lower middle pelvis ☐ Lower right ☐ Lower left ☐ Upper abdomen ☐ Belly button ☐ Vagina ☐ Rectum ☐ Lower back ☐ Groin ☐ Buttock ☐ Leg (R / L) ☐ Right shoulder ☐ Left shoulder ☐ Chest

Which words describe your pain? ☐ Cramping ☐ Sharp / stabbing ☐ Burning ☐ Electric / shooting ☐ Aching ☐ Pressure ☐ Constant ☐ Comes and goes

When does your pain happen? ☐ Days before period ☐ During period ☐ After period ☐ At ovulation (mid-cycle) ☐ All month ☐ No pattern

Over time, your pain is: ☐ Getting worse ☐ About the same ☐ Getting better **Days of pain per month:** _____

	Yes	No	Worse w/ period		Yes	No	Worse w/ period
Pain with physical exercise	☐	☐	☐	Shooting pain down the leg	☐	☐	☐
Cramping pain without bleeding	☐	☐	☐	Numbness in leg or foot	☐	☐	☐
Back pain worse with periods	☐	☐	☐	Pain with sitting	☐	☐	☐
Left hip pain	☐	☐	☐	Pain inserting a tampon	☐	☐	☐
Right hip pain	☐	☐	☐	Pain with pelvic exams	☐	☐	☐
Buttock pain	☐	☐	☐	Avoid intercourse due to pain	☐	☐	☐

If you avoid intercourse because of pain, how often? ☐ Sometimes ☐ Often ☐ Always ☐ Not sexually active

How many years have you had these symptoms? _____

Work / school status: ☐ Working full-time ☐ Working part-time ☐ Student ☐ Unable to work due to pain ☐ On disability ☐ Not working

Missed because of pain	Days per month	Days in past year	Not applicable
Missed work (or left early)			☐
Missed school / classes			☐
Missed family or social events			☐

Total emergency room visits for pain _____ **Total hospital admissions for pain** _____

Date (mo/yr)	Hospital / ER	Visit type	Reason / what was done (tests, CT, surgery, medicines)
		☐ ER ☐ Admitted	
		☐ ER ☐ Admitted	
		☐ ER ☐ Admitted	
		☐ ER ☐ Admitted	

5. BOWEL SYMPTOMS

Check Yes or No. If the symptom is worse around your period, also check the last box.

	Yes	No	Worse w/ period		Yes	No	Worse w/ period
Nausea	☐	☐	☐	Diarrhea	☐	☐	☐
Vomiting	☐	☐	☐	Painful bowel movements	☐	☐	☐
Feel full quickly	☐	☐	☐	Rectal pain or pressure	☐	☐	☐
Bloating	☐	☐	☐	Straining / not fully emptying	☐	☐	☐
Gas pains	☐	☐	☐	Blood in stool	☐	☐	☐
Constipation	☐	☐	☐	Blood in stool during period	☐	☐	☐

Your usual stool type: ☐ Hard lumps ☐ Lumpy / hard sausage ☐ Smooth / normal ☐ Soft blobs ☐ Mushy ☐ Watery ☐ Alternates hard and loose

Bowel movements per day (or per week) _____

Bowel / GI tests and procedures you have had:

Procedure	Had it	Times	Year / result	Procedure	Had it	Times	Year / result
Colonoscopy	☐			Capsule endoscopy	☐		
Upper endoscopy / EGD	☐			SIBO breath test	☐		
Flexible sigmoidoscopy	☐			Other GI test	☐		

6. BLADDER AND KIDNEY SYMPTOMS

	Yes	No	Worse w/ period		Yes	No	Worse w/ period
Frequent urination	☐	☐	☐	Blood in urine	☐	☐	☐
Urgent need to urinate	☐	☐	☐	UTI symptoms but negative cultures	☐	☐	☐
Burning with urination	☐	☐	☐	Flank (side/kidney) pain	☐	☐	☐
Incomplete bladder emptying	☐	☐	☐	Pain toward the end of urination	☐	☐	☐

Times you urinate during the day _____ **Times you wake at night to urinate** _____

Ever told you had a blocked kidney (hydronephrosis)? ☐ Yes ☐ No **Recurrent UTIs (3+ per year)?** ☐ Yes ☐ No

Bladder / urology tests and procedures you have had:

Procedure	Had it	Times	Year / result	Procedure	Had it	Times	Year / result
Cystoscopy	☐			Ureteral stent	☐		
Urodynamic testing	☐			Kidney US / CT urogram	☐		
Bladder instillations	☐			Other urology test	☐		

Patient name _____

7. SYMPTOMS OUTSIDE THE PELVIS

These can be signs of endometriosis on the diaphragm, chest, or abdominal wall.

	Yes	No	Worse w/ period		Yes	No	Worse w/ period
Right shoulder pain with period	☐	☐	☐	Ever had a collapsed lung	☐	☐	☐
Left shoulder pain with period	☐	☐	☐	Painful lump at belly button	☐	☐	☐
Chest pain with period	☐	☐	☐	Painful lump at C-section scar	☐	☐	☐
Shortness of breath with period	☐	☐	☐	Painful lump in the groin	☐	☐	☐
Coughing up blood with period	☐	☐	☐	Pain under the ribs	☐	☐	☐

8. HORMONAL AND MEDICAL TREATMENT (PAST AND PRESENT)

Check each medication you have taken. Tell us how long, whether it helped, and why you stopped (use the reasons listed below the table).

Medication	Used	How long	Did it help?	Why stopped / side effects
Birth control pill - monthly	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Birth control pill - continuous	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Birth control patch (Xulane, Twirla)	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Vaginal ring (NuvaRing, Annovera)	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Norethindrone (Aygestin)	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Slynd / Visanne (dienogest)	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Depo-Provera shot	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Nexplanon implant	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Mirena / hormonal IUD	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Lupron	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Orilissa	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Myfembree	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Oriahnn	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Letrozole / anastrozole	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
Danazol	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	
	☐	☐ <3 mo ☐ 3-6 ☐ 6-12 ☐ >12	☐ Yes ☐ Some ☐ No	

Names of birth control pills / brands you have tried (if you recall) _____

Reasons you stopped any hormonal medication (check all that apply): ☐ Did not help ☐ Headaches / migraine ☐ Depression ☐ Mood swings / irritability ☐ Anxiety ☐ Breakthrough / irregular bleeding ☐ Heavier bleeding ☐ Weight gain ☐ Bloating ☐ Acne ☐ Hair loss ☐ Low sex drive ☐ Nausea ☐ Breast tenderness ☐ Hot flashes ☐ Joint / bone pain ☐ Bone density loss ☐ Blood clot ☐ High blood pressure ☐ Doctor advised me to stop ☐ Wanted pregnancy ☐ Cost / insurance ☐ Other

Other reasons / details _____

If you used Lupron, did you also take add-back therapy? ☐ Yes ☐ No ☐ Not sure

Do you take opioid (narcotic) pain medication? ☐ Daily now ☐ Sometimes now ☐ In the past only ☐ Never

Patient name _____

Procedures / other treatments tried: ☐ Nerve block ☐ Trigger point injections ☐ Botox injections ☐ Cannabis / CBD ☐ Dietary changes ☐ TENS unit

Other specialists and therapies you have tried:

Specialist / therapy	Tried	Did it help?	Specialist / therapy	Tried	Did it help?
Pelvic floor physical therapy	☐	☐ Yes ☐ Some ☐ No	Massage / myofascial release	☐	☐ Yes ☐ Some ☐ No
Pain management specialist	☐	☐ Yes ☐ Some ☐ No	Nutritionist / dietitian	☐	☐ Yes ☐ Some ☐ No
Functional medicine	☐	☐ Yes ☐ Some ☐ No	Pain psychologist / counselor	☐	☐ Yes ☐ Some ☐ No
Integrative / holistic medicine	☐	☐ Yes ☐ Some ☐ No	Sex therapist	☐	☐ Yes ☐ Some ☐ No
Naturopath	☐	☐ Yes ☐ Some ☐ No	Yoga / meditation	☐	☐ Yes ☐ Some ☐ No
Acupuncture	☐	☐ Yes ☐ Some ☐ No	Other:	☐	☐ Yes ☐ Some ☐ No
Chiropractor	☐	☐ Yes ☐ Some ☐ No			

Provider names and number of visits _____

Pain and nerve medications you have tried:

Medication	Used	Did it help?	Medication	Used	Did it help?
Ibuprofen / naproxen (NSAID)	☐	☐ Yes ☐ Some ☐ No	Amitriptyline / nortriptyline	☐	☐ Yes ☐ Some ☐ No
Celecoxib (Celebrex)	☐	☐ Yes ☐ Some ☐ No	Duloxetine (Cymbalta)	☐	☐ Yes ☐ Some ☐ No
Acetaminophen (Tylenol)	☐	☐ Yes ☐ Some ☐ No	Muscle relaxant (cyclobenzaprine)	☐	☐ Yes ☐ Some ☐ No
Gabapentin (Neurontin)	☐	☐ Yes ☐ Some ☐ No	Vaginal valium (diazepam)	☐	☐ Yes ☐ Some ☐ No
Pregabalin (Lyrica)	☐	☐ Yes ☐ Some ☐ No	Tramadol / opioids	☐	☐ Yes ☐ Some ☐ No

Doses / side effects _____

9. HORMONE SAFETY AND BLOOD CLOT RISK

Some conditions make estrogen or other hormonal treatments unsafe. Please answer carefully.

	Yes	No		Yes	No
I have had a blood clot (DVT / PE)	☐	☐	I smoke or vape nicotine	☐	☐
I have a clotting disorder	☐	☐	Lupus / antiphospholipid antibodies	☐	☐
Family member had a blood clot	☐	☐	Breast cancer (personal history)	☐	☐
Family member has a clotting disorder	☐	☐	Liver disease or liver tumor	☐	☐
Stroke or mini-stroke (TIA)	☐	☐	Low bone density / osteoporosis	☐	☐
Heart attack / heart disease	☐	☐	I take a blood thinner now	☐	☐
Migraine with aura (visual changes)	☐	☐	Told not to take estrogen / hormones	☐	☐
High blood pressure	☐	☐	Clot while pregnant or on hormones	☐	☐

Clotting disorder (you or family): ☐ Factor V Leiden ☐ Prothrombin gene mutation ☐ Protein C deficiency ☐ Protein S deficiency ☐ Antithrombin deficiency ☐ Antiphospholipid syndrome ☐ MTHFR ☐ Other / not sure **Who has it:** _____

Blood clot details (year, location, what caused it) _____

Blood thinner name and dose _____ **Prescribed by** _____

Hematologist name _____ **Practice / phone** _____

If told not to take hormones: who told you and why? _____

Patient name _____

10. PRIOR SURGERY FOR ENDOMETRIOSIS OR PELVIC PAIN

List each surgery. If you are not sure of a detail, write "unknown".

Year	Surgeon / hospital	Approach	Treatment	Endo on biopsy?	Organs removed / repaired	Months of relief
		☐ Lap ☐ Robotic ☐ Open	☐ Ablation ☐ Excision ☐ Unsure	☐ Y ☐ N ☐ ?		
		☐ Lap ☐ Robotic ☐ Open	☐ Ablation ☐ Excision ☐ Unsure	☐ Y ☐ N ☐ ?		
		☐ Lap ☐ Robotic ☐ Open	☐ Ablation ☐ Excision ☐ Unsure	☐ Y ☐ N ☐ ?		
		☐ Lap ☐ Robotic ☐ Open	☐ Ablation ☐ Excision ☐ Unsure	☐ Y ☐ N ☐ ?		

Total number of surgeries _____ **Stage of endometriosis you were told (1-4)** _____

Hysterectomy? ☐ No ☐ Total (cervix removed) ☐ Supracervical (cervix kept) **Year:** _____

Ovaries removed? ☐ None ☐ Left ☐ Right ☐ Both

Surgery on bowel, bladder, or ureter? ☐ Yes ☐ No ☐ Not sure

Did your symptoms return after surgery? ☐ Yes ☐ No ☐ Never went away **Months until return:** _____

If ovaries were removed, do you take estrogen / HRT? ☐ Yes ☐ No

Operative reports and pathology: ☐ I will bring them ☐ Please request them for me (records release attached) ☐ Not available

11. IMAGING, LABS AND RECORDS

Test	Had it?	Year	Facility / result
Pelvic / transvaginal ultrasound	☐		
Pelvic MRI	☐		
MRI with endometriosis protocol	☐		
CT scan abdomen / pelvis	☐		
Bone density scan (DEXA)	☐		
Mammogram	☐		
Genetic testing (BRCA, etc.)	☐		

Lab	Done	Date / result	Lab	Done	Date / result
CA-125	☐		Ferritin / iron	☐	
Hemoglobin / CBC	☐		Biopsy / pathology	☐	
AMH (egg reserve)	☐				

Records you will bring (or ask us to request): ☐ Imaging reports ☐ Imaging discs (CD) ☐ Lab results ☐ Operative reports ☐ Pathology reports / slides ☐ Prior consult notes

12. HOW YOUR SYMPTOMS AFFECT YOUR LIFE

Over the past 4 weeks, how often has your pain:

	Never	Rarely	Sometimes	Often	Always
Kept you from work or school	☐	☐	☐	☐	☐
Disturbed your sleep	☐	☐	☐	☐	☐
Affected intimacy or relationships	☐	☐	☐	☐	☐
Stopped you exercising or going out	☐	☐	☐	☐	☐
Made you feel you have lost control	☐	☐	☐	☐	☐

Patient name _____

Over the past 2 weeks, how often have you been bothered by the following? (PHQ-4)

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

PART B | GENERAL MEDICAL HISTORY

13. PAST MEDICAL HISTORY

Check any condition you have now or have had in the past.

General: ☐ High blood pressure ☐ Diabetes ☐ High cholesterol ☐ Heart disease ☐ Heart murmur / valve problem ☐ Irregular heartbeat ☐ Asthma ☐ COPD ☐ Sleep apnea ☐ Thyroid disease ☐ Kidney disease ☐ Kidney stones ☐ Liver disease / hepatitis ☐ Anemia ☐ Bleeding disorder ☐ Easy bruising ☐ Seizures ☐ Stroke ☐ Cancer ☐ HIV ☐ Obesity ☐ Arthritis ☐ Back / disc problems

Digestive: ☐ Acid reflux (GERD) ☐ Irritable bowel syndrome (IBS) ☐ SIBO ☐ Crohn's disease ☐ Ulcerative colitis ☐ Celiac disease ☐ Diverticulitis ☐ Gallbladder disease ☐ Hernia ☐ Hemorrhoids / fissure

Pelvic and pain: ☐ Interstitial cystitis / bladder pain ☐ Pelvic floor dysfunction ☐ Vulvodynia ☐ Adenomyosis ☐ Fibroids ☐ Ovarian cysts / endometrioma ☐ PMOS (formerly known as PCOS) ☐ Pelvic congestion ☐ Pudendal neuralgia

Whole-body: ☐ Fibromyalgia ☐ Migraine ☐ POTS ☐ Hypermobility / Ehlers-Danlos ☐ Lupus ☐ Rheumatoid arthritis ☐ Other autoimmune disease ☐ Chronic fatigue ☐ Mast cell disorder

Mental health: ☐ Anxiety ☐ Depression ☐ PTSD ☐ Eating disorder ☐ ADHD ☐ Other

Cancer type / other conditions / details _____

14. OTHER SURGERIES AND SURGICAL READINESS

Include all other surgeries (C-section, appendix, gallbladder, hernia, breast, orthopedic, etc.).

Surgery / hospital / complications	Year	Surgery / hospital / complications	Year

	Yes	No		Yes	No
Problem with anesthesia (you)	☐	☐	Would refuse blood transfusion	☐	☐
Problem with anesthesia (family)	☐	☐	Pacemaker / defibrillator	☐	☐
Severe nausea after anesthesia	☐	☐	Mesh implant (hernia, sling, prolapse)	☐	☐
Malignant hyperthermia (you / family)	☐	☐	Prior pelvic / abdominal radiation	☐	☐
Told you have a difficult airway	☐	☐	Ostomy (now or in the past)	☐	☐
Heavy bleeding after surgery / dental work	☐	☐	I use a CPAP machine	☐	☐
Blood transfusion ever	☐	☐	Can climb 2 flights of stairs without stopping	☐	☐

Details _____

Patient name _____

15. CURRENT MEDICATIONS AND ALLERGIES

List ALL medications, including vitamins, supplements, and over-the-counter medicines. You may attach a list.

Medication and dose	How often	Medication and dose	How often

GLP-1 / weight-loss medication: ☐ None ☐ Ozempic / Wegovy ☐ Mounjaro / Zepbound ☐ Saxenda / Victoza ☐ Rybelsus ☐ Other

GLP-1 dose _____ **Date of last dose** _____

Supplements: ☐ None ☐ Fish oil / omega-3 ☐ Vitamin E ☐ Turmeric / curcumin ☐ Ginkgo ☐ Garlic ☐ Ginseng ☐ St. John's wort ☐ Other herbal **Other:** _____

Allergies: ☐ No known allergies ☐ Latex ☐ Iodine / CT contrast ☐ Adhesive tape ☐ Chlorhexidine ☐ Penicillin ☐ Sulfa ☐ Opioids ☐ NSAIDs

Allergy	Reaction	Allergy	Reaction

Preferred pharmacy (name / location / phone) _____

16. FAMILY HISTORY

Write the relationship (mother, sister, aunt, etc.).

Condition	Relative	Condition	Relative
Endometriosis		Breast cancer	
Adenomyosis		Colon cancer	
Ovarian cancer		BRCA gene mutation	
Uterine cancer		Lynch syndrome	
Blood clots		Clotting disorder	
Bleeding disorder		Problems with anesthesia	
Autoimmune disease		Heart disease / stroke	

Are you of Ashkenazi Jewish ancestry? (affects BRCA risk) ☐ Yes ☐ No ☐ Not sure

17. SOCIAL HISTORY

Height _____ **Weight** _____ **Occupation** _____

Tobacco / nicotine: ☐ Never ☐ Former ☐ Current cigarettes ☐ Vape / e-cigarette **Packs/day, years, quit date:** _____

Alcohol: ☐ None ☐ 1-3 drinks/week ☐ 4-7 drinks/week ☐ More than 7/week

Cannabis: ☐ Never ☐ Occasionally ☐ Daily **Other recreational drugs:** ☐ No ☐ Yes

Exercise: ☐ Rarely ☐ 1-2 times/week ☐ 3+ times/week ☐ Limited by pain

Relationship status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced / separated ☐ Widowed

Do you have someone to help you at home after surgery? ☐ Yes ☐ No ☐ Not sure

Patient name _____

18. YOUR PREFERENCES AND VISIT PLANNING

Preferred language _____ **Interpreter needed? (Yes / No)** _____

Best way to reach you: ☐ Patient portal ☐ Text ☐ Phone call ☐ Email

For the pelvic exam, would you like a chaperone? ☐ Yes ☐ No ☐ No preference

Anything that would make your exam more comfortable? _____

Emergency contact name _____ **Relationship** _____ **Phone** _____

Health care proxy / advance directive? ☐ Yes ☐ No **Proxy name:** _____

Travel time to our office: ☐ Under 30 min ☐ 30-60 min ☐ 1-2 hours ☐ Over 2 hours / out of state

After surgery you plan to recover: ☐ At home ☐ Hotel near the hospital ☐ With family nearby ☐ Not sure

Will you need FMLA / disability paperwork? ☐ Yes ☐ No ☐ Not sure

19. YOUR CARE TEAM

Doctors we may contact or send records to.

Role	Name / practice / phone	Role	Name / practice / phone
Primary care doctor		Pain management	
Gynecologist		Pelvic floor PT	
Gastroenterologist		Functional / integrative	
Urologist		Fertility specialist	
Hematologist		Other	

Anything else you would like Dr. Singhal to know? _____

I confirm that the information above is accurate and complete to the best of my knowledge.

Patient signature _____ **Date** _____

FOR OFFICE USE **Reviewed by** _____ **Date** _____ ☐ Entered in chart