1763 Freedom Drive
Suite 117
Naperville, IL 60563

The Wright Center for Women's Health
Personalized Luxury Healthcare

Office: (630) 687-9595
Fax: (630) 839-5805
thewrightobgyn.com

In an effort to provide the best experience during your office visit today and help us keep current on your health, please take a few minutes to complete the following questions. Thank you!

Name:_____ Date:_____

CONTRACEPTION

1. What is your current form of birth control?_____
2. How long have you been using your current form of birth control? (Please check one)
   2 years of less_____ 3-5 years_____ 6-10 years_____ Over 10 years_____
3. Do you currently have children? Yes No If yes, how many?_____
4. When are you planning on having another child? (Please check one)
   Within the next year_____ Within the next 5 years_____
   Within the next 10 years_____ My family is complete_____
5. Would you like information on a gentle, hormone-free permanent birth control procedure performed in the comfort of our office?

MENSTRUAL PERIODS

1. How long does your average monthly period last? _____ Days
2. Do you ever feel as though your periods impact the quality of your life? YES NO
3. Do you ever experience irregular or inconsistent bleeding patters? YES NO
4. Do tampons or sanitary napkins quickly become soaked, causing a frequent need to change them? YES NO
5. Do you often experience heavy bleeding with clotting? YES NO
6. Do you have a heavy period, even while using birth control pills? YES NO
7. Are you exceptionally tired or weak during your period? YES NO
8. Have you missed work because of your periods? YES NO
9. Do you rearrange social events or daily activities to accommodate your period? YES NO
10. Do you tend to stay home when you have your period because it is easier? YES NO
11. To be prepared, do you carry large quantities of feminine products or even a change of clothes? YES NO
12. Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly period? YES NO

URINARY HEALTH

1. Do you ever leak urine when you cough, laugh or sneeze? YES NO
2. Do you ever feel as though you have to urinate urgently? YES NO
3. Do you feel like you have to urinate too frequently? YES NO
4. Do you ever experience painful urination? YES NO