FEELING BETTER FROM THE INSIDE OUT

TIRPACK MEDICAL PROCEDURES
JILL TIRPACK, MD, FACOG

PATIENT INTAKE FORM

Personal Information

Name:		DOB:	
Address:		Home Phone:	
City/State/Zip:		Cell Phone:	
Email:		Skin Type:	I II III IV V VI

Gynecological History

Last PAP:	___________________ (mm / dd / yy)
PAP Results:	○ Normal ○ Abnormal
History of Abnormal PAP Smears?	○ No ○ Yes, if so nature of diagnosis, treatment and follow up: _____________ _____________________________
Last Menstrual Period:	___________________ (mm / dd / yy)
Indications for Treatment:	

Medical History

Past Medical Diagnoses:	
Past Surgical History (including Gynecological)	
Current Medications:	
Allergies:	
HSV History:	○ Yes ○ No Prophylaxis Treatment Started: ○ Yes ○ No

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EMPOWER **RF** PRE-TREATMENT QUESTIONNAIRE

Patient Name: ______________________________ Date: ______________

Height:	Weight:	Number of Vaginal Deliveries:
Lacerations/Episiotomy: O Yes O No		Weight of Babies:
Do you have Diabetes: O Yes O No		Do you have Hypertension: O Yes O No

Are you menopausal? O Yes O No Are you Post-menopausal? O Yes O No
If so, do you have vaginal pressure? O Yes O No

Are you able to wear tampons? O Yes O No

On average, how often do you urinate per day?

How many times do you wake up at night to urinate?

Do you wear pads for leaking? O Yes O No If so, how many per day? ______

How often do you leak urine: O ___ x per day O ___ x per week

When you have an accident, do you have: O Leaking (small drops) or O Full Loss

Are you currently taking any diuretics or medication for incontinence/overactive bladder? O Yes O No If so, what?____________

Have you had any vaginal procedures or surgeries? (hysterectomy, A/P repair, bladder sling, Votiva, MonaLisa, etc) O Yes O No If so, what?

Are you using Hormone Replacement Therapy: O Yes O No
Results?

Are you sexually active: O Yes O No

Do you have frequent Urinary Tract Infections? O Yes O No How Often: _______
Do you have frequent Bacterial Vaginal Infections? O Yes O No How Often: _______
Do you have frequent Yeast Infections? O Yes O No How Often: _______

Have you been diagnosed with one of the following? *Please check all that apply.*
O Lichen Sclerosis O Autoimmune Disorder O Pelvic Floor Dysfunction
O Herpes Simplex/Virus O Pudendal Nerve Pain or Damage O Interstitial Cystitis
What medications have you tried or do you take for these conditions? __________

For later use:
How would you describe your results from EmpowerRF?

Why are you choosing an EmpowerRF treatment today? ______________________________

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EMPOWER**RF** PRE-TREATMENT QUESTIONNAIRE

[Continued]

Symptom Scale: 0 = Never 1= Occasionally 2 = Mild 3 = Moderately 4= Frequently/Severe

DO YOU.......	NO	YES			
Have tissue tearing?	0	1	2	3	4
Have tissue pain?	0	1	2	3	4
Have tissue itching?	0	1	2	3	4
Have pain with sex?	0	1	2	3	4
Have decreased sensation or decreased orgasm?	0	1	2	3	4
Experience urine leakage associated with feeling of urgency?	0	1	2	3	4
Experience urine leakage related to coughing, sneezing, or laughing?	0	1	2	3	4
Experience small amounts of urine leakage? (drops)	0	1	2	3	4
Experience difficulty emptying your bladder?	0	1	2	3	4
Experience pain or discomfort in the lower abdomen or genital region?	0	1	2	3	4
Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1	2	3	4
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1	2	3	4
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1	2	3	4
Experience fecal incontinence?	0	1	2	3	4

Is there anything else you'd like us to know?