NORTHSHORE WOMEN'S SEXUAL HEALTH PROGRAM
NEW PATIENT QUESTIONNAIRE

Name you wish to be called :

Pronouns: she/her they/them he/him other

Please describe current sexual health concerns (include duration of symptoms):

Prior interventions/treatments:

What results are you hoping for in seeking treatment?

GYNECOLOGIC HISTORY

Date of last menstrual period:

Age at first period: Age at menopause (if applicable):

Frequency of periods: # of days of bleeding:

Pain or heavy flow:

Do periods interfere with your life?

History of abnormal pap:

History of sexually transmitted infections:

Gynecologic surgeries:

Hormone replacement therapy (type and duration of use):

Contraception now: Contraception methods used in past:

Planning future pregnancy? If yes, are you desiring pregnancy now?

Pregnancies:

Year	Type of Delivery (vaginal, forceps, c-section)	Complications

Urinary or bowel problems (incontinence, constipation, etc):

MEDICATIONS/SUPPLEMENTS (please include dose and duration of use)

SUBSTANCE USE (please include frequency and duration of use)

Alcohol:

Smoking/vaping:

Marijuana:

Other drugs:

MENTAL HEALTH HISTORY

Do you see a therapist or have you in the past? Please share name and duration of treatment.

:

Medications for depression, anxiety, other psychiatric conditions:
(please include duration of use and any sexual side effects noted with treatment)

FAMILY/RELIGIOUS BACKGROUND

Religion:

Any religious beliefs/practices, childhood experiences or family beliefs affecting your sexual health:

DAILY LIFE ACTIVITIES

Occupation: Hours per week:

Hours of sleep per night:

Exercise (type and frequency):

Persons living in your home with you (include name, relationship, age):

SEXUAL HISTORY

Partners: Male Women Both Non-binary

# of partners in past year: # of partners total:

Current partner (name):

(if no current partner, please answer re: your most recent partner)

Duration of relationship:

Married (if yes, for how long):

Frequency of physical intimacy with your partner (not limited to intercourse):

Would you like this to be more often?

% of satisfying encounters per month:

Frequency of self-pleasuring:

% of satisfying encounters per month:

When in this relationship was sex best or most satisfying?

Does your partner have any sexual/performance problems?

Does lack of privacy interfere with your sexual relationship?

Pain with sex: never sometimes always

History of abuse/non-consensual sex:

Age at first consensual sexual experience:

Please answer each of the following yes or no questions:

1. In the past was your level of sexual desire or interest good and satisfying to you?

2. Has there been a decrease in your level of sexual desire or interest?

3. Are you bothered by your decreased level of sexual desire or interest?

4. Would you like your level of sexual desire or interest to increase?

5. Please circle any factors that you feel may be contributing to your current decrease in desire (feel free to elaborate further in the space below)

A: An operation, depression, injuries, or other medical condition
B: Medication, drugs or alcohol you are currently taking
C: Pregnancy, recent childbirth, menopausal symptoms
D: Other sexual issues you may be having (pain, decreased arousal or orgasm)
E: Your partner's sexual problems
F: Dissatisfaction with your relationship or partner
G: Stress or fatigue

Thank you for sharing your answers to these questions. It will help us to address your concerns more thoroughly and may help you to identify issues you wish to discuss at your visit. I look forward to meeting you.

Please call 847-941-7610 with questions or if you need to cancel/reschedule. Please be aware that there is a $50 fee for no-shows or cancellations less than 24 hours in advance.

Mary Faith Terkildsen, MD