Age:	Date of last PAP smear:	
Onset of Menopause (natural or induced):		
Menses within the past year	NO	YES
Itchiness and burning sensation	NO	YES
Discomfort related to vaginal laxity *without a pelvic organ prolapse *with a pelvic organ prolapse	 NO NO	 YES YES <POP-Q Stage 1 > POP- Q Stage 2
Decreased vaginal lubrication	NO	YES
Sexually Active	NO	YES
Pain during sexual intercourse	NO	YES
Bleeding during sexual activity	NO	YES Frequency?
Atypical vaginal/ uterine bleeding	NO	YES Frequency?
Thick, whitish or yellowish vaginal discharge	NO	YES
Hysterectomy	NO	YES When?
Pelvic floor surgery	NO	YES When?
History of oestrogen therapy	NO	YES Outcome?
Stress urinary incontinency	NO	YES during… Sneeze/Cough/Laugh Exercise/Heavy object lifting
Stinging during urination	NO	YES
Medical history of cancer	NO	YES what? When?
Systemic disease	NO	YES what?
Medical history of genital infections	NO	YES what? When?
Medical history of urinary tract infection	NO	YES when?

My signature certifies that I have duly read and understood the content of this informed consent form, and gave the accurate information as to my health condition. I hereby freely consent to the AcuPulse Femtouch procedure.

Name of patient (please print) Signature of Patient Date

Name of witness (please print) Signature of Patient Date

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