



REPLY TO  
ATTENTION OF:

**DEPARTMENT OF THE ARMY**  
HEADQUARTERS, CARL R. DARNALL ARMY MEDICAL CENTER  
36000 DARNALL LOOP  
FORT HOOD, TEXAS 76544-4752

MCXI-DOS-PA

December 2013

**MEMO FOR RECORD: New Patients**  
**SUBJECT: Welcome letter**

Welcome to the Carl. R Darnall Army Medical Center Pain Management Clinic.

You have been referred to our program by your health care Provider because of your persistent chronic pain. The causes of chronic pain are completely different from acute pain which occurs for example after a broken bone or surgery. As tissues of the body heal after 6 weeks and acute pain resolves, the causes of chronic pain involve different mechanisms in the body and therefore require different treatments. Chronic pain can affect sleep, activity, mood, and other areas of your life which then affect your overall quality of life.

Our program consists of an integrative, comprehensive approach by a multidisciplinary pain team to help you more effectively manage your persistent pain. To better understand the effects of pain on your quality of life, you will be evaluated by one or more of our program's team members. We will identify and review with you a treatment plan for your pain management. When your pain is stabilized and well managed, follow up care will be forwarded to your Primary Care Manager (PCM) for continued management.

We encourage adult family member participation and we welcome them to attend all appointments with you, pain affects the whole family. We look forward to assisting you in your pain management. If you have any questions or concerns, please feel free to ask one of our pain management team members.

PAIN MANAGEMENT SERVICES  
CARL R. DARNALL ARMY MEDICAL CENTER  
FORT HOOD, TEXAS 76544

MCXI-DOS-PA

December 2013

PAIN MANAGEMENT ATTENDANCE/NO-SHOW POLICY

1. **PURPOSE:** To establish a Pain Management Clinic attendance policy IAW command guidelines.

2. **RESPONSIBILITIES:**

- a. Chief of the Pain Management Clinic has overall responsibility for this policy.
- b. All staff members assigned or attached to the Pain Management Clinic have direct responsibility to enforce this policy.

3. **ACTIONS:**

a. All patients with scheduled appointments should report 15 minutes prior to their appointment time in order to be signed in appropriately and to complete pre-evaluation paperwork.

b. Patients reporting 15 minutes or greater after their appointment time may be considered a no-show and will have their appointment rescheduled.

c. For those patients who arrive more than 15 minutes after their appointment time, the medical clerk/receptionist should ask the patient to have a seat and notify the Physician. The Physician involved can then make the decision to see the patient late if possible or to reschedule the patient to ensure quality care is rendered and other scheduled patients are not inconvenienced.

d. The 24-hour cancellation line is available to cancel appointments at 288-8888, or the patient may call the Pain Management Clinic at 288-8931 during duty hours 0730-1600. Patients must cancel their appointment 24 hours prior to their scheduled appointment or their appointment may be annotated as a no-show. Exceptions can be made on a case-by-case basis for clear extenuating circumstances.

e. Patients should receive a verbal and/or written notice of this policy when making their first Pain Management Clinic appointment or at the time of their first visit to the clinic. The written notification for the active soldier is shown below.

4. **ACTIVE DUTY SOLDIERS**

(a) Must report 15 minutes prior to their appointment time in order to be signed-in appropriately. Soldier's reporting more than 15 minutes after their appointment time may be considered a no-show. Soldiers who miss two scheduled Pain Management Clinic appointments without prior cancellation may require a written request from their First Sergeant/ Commander for resumption of appointments. Soldiers must call 24 hours prior to their appointment time to cancel or the appointment may be counted as a no-show. To cancel appointments, call 288-8931.

Patient signature / date: \_\_\_\_\_

Printed patient name: \_\_\_\_\_



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### **MEDICATION REFILL POLICY**

1. Appropriately managing pain is a team effort between the Pain Management Physicians, the nurse, and the patient. Please be aware that Pain Physicians may not be available for patient request and consults due to other obligations, such as Anesthesiology call and Operating Room coverage.

- a. No medication will be refilled early without proper documentation and reasoning.
- b. If entered into Sole Provider Agreement, you agree to not receive opioids medications from any other doctors without the knowledge and consent of your pain doctor.
- c. Prescription refills will be authorized only during regular office hours.
- d. Please allow 72 hours for all medication refills.
- e. It is the patient's responsibility to know when his/her pain medication will run out.
- f. Pain Management Physicians will refill only those medications prescribed by Pain Management Physicians.
- g. **DO NOT** walk into the Pain Clinic to request a medication refill.
- h. Patients requiring medication refills may call the Pain Management Clinic at 288-8931 between the 0800-1600 hours every Monday thru Friday. Please leave a message with the MSA or on the voice mail. State exactly which medication you need to have refilled. Please leave your phone number, whom your Physician is and the last 4 of your social security number.
- i. Your Pain Clinic Physician will review your records, and order appropriate pain medications. We will contact you to confirm any information, answer questions, and let you know your prescription is ready.
- j. Patients will be referred to their Troop Medical Clinic, referring physicians, or primary care physician for medication refills of medications not prescribed by the Pain Clinic.

*We understand that emergencies can occur and under some circumstances, exceptions to these guidelines may be made.*

**PRIVACY ACT STATEMENT - HEALTH CARE RECORDS**

*THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.*

**1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)**

**Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.**

**2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED**

**This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.**

**3. ROUTINE USES**

**The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.**

**4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION**

**In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.**

**This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.**

**Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.**

SIGNATURE OF PATIENT OR SPONSOR

SSN OF MEMBER OR SPONSOR

DATE

CARL R DARNALL ARMY MEDICAL CENTER

PAIN MANAGEMENT CLINIC

PATIENT PAIN PROFILE (P3)

NAME: \_\_\_\_\_ DATE OF VISIT \_\_\_\_/\_\_\_\_/\_\_\_\_ (D/M/YYYY)  
(LAST, FIRST, MIDDLE INITIAL)

SEX: \_\_\_\_ Female \_\_\_\_ Male Age: \_\_\_\_ RANK: \_\_\_\_ OCCUPATION: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_  
Name of Doctor/Provider Specialty of Referring Doctor/Provider

**INSTRUCTIONS:** Please fill out each section, if a section does not apply to you, please answer it "N/A"

**PAIN DESCRIPTION**

**1. CHIEF COMPLAINT (REASON FOR VISIT)** \_\_\_\_\_

**2. Are you currently on a physical profile?** \_\_\_\_ YES \_\_\_\_ NO IF "YES" what is the reason?  
\_\_\_\_\_

**3. Are you currently involved in the Medical Evaluation Board (MEB) process?** \_\_\_\_ YES \_\_\_\_ NO

**4. Are you a member of the Warrior Transition Brigade (WTB)?** \_\_\_\_ YES \_\_\_\_ NO

**5. HAND DOMINANCE:** \_\_\_\_ Right Handed \_\_\_\_ Left Handed \_\_\_\_ Ambidextrous

**6. In general, would you say your health is:** \_\_\_\_ Excellent \_\_\_\_ Very Good \_\_\_\_ Good \_\_\_\_ Fair  
\_\_\_\_ Poor

**7. When did you notice your pain?** \_\_\_\_\_ Month(s) \_\_\_\_\_ Year (s)

**8. How did your pain begin?**

\_\_\_\_ Pain just began, no reason

\_\_\_\_ Other Military Deployment

\_\_\_\_ Motor vehicle accident

\_\_\_\_ Accident at work

\_\_\_\_ Following surgery

\_\_\_\_ Accident at home

\_\_\_\_ Operation Iraqi Freedom (OIF)

\_\_\_\_ Operation Enduring Freedom (OEF)

\_\_\_\_ Other, please explain \_\_\_\_\_

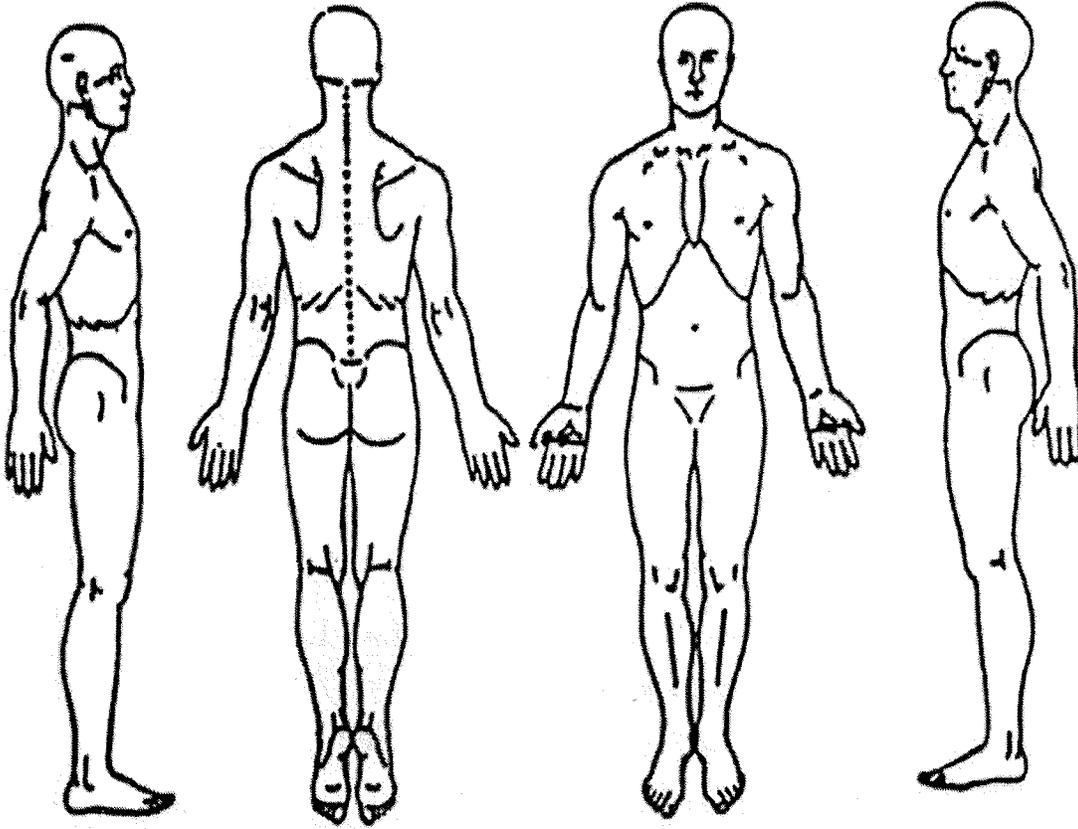
9. Indicate the location of your pain. Please shade the painful areas.

RIGHT

BACK

FRONT

LEFT



**10. Describe the duration of your pain;** \_\_\_\_\_ Constant or \_\_\_\_\_ Intermittent (comes and goes)

**11. How would you describe your pain?**

\_\_\_ Dull      \_\_\_ Sharp      \_\_\_ Throbbing      \_\_\_ Burning      \_\_\_ Penetrating

\_\_\_ Aching      \_\_\_ Stabbing      \_\_\_ Cramping      \_\_\_ Shooting

\_\_\_ Other \_\_\_\_\_

**12. Do you have any of the following symptoms associated with your pain?**

\_\_\_ Numbness      \_\_\_ Coldness      \_\_\_ Muscle Spasms

\_\_\_ Tingling      \_\_\_ Sweating      \_\_\_ Loss of Control of bowels/bladder

\_\_\_ Weakness (in the arms or legs)      \_\_\_ Skin discoloration

\_\_\_ OTHER, explain \_\_\_\_\_

**13. Does your pain travel anywhere?**    \_\_\_ YES    \_\_\_ NO

If "YES" indicate where; \_\_\_\_\_

**14. What time of the day are you in the MOST pain?**

\_\_\_ Morning, on arising      \_\_\_ Bedtime

\_\_\_ Later in the morning      \_\_\_ Night, during usual sleeping hours

\_\_\_ Afternoon      \_\_\_ Pain is always the same

\_\_\_ Evening      \_\_\_ Pain varies, but is not worse at any particular time

**15. What time of the day are you in the LEAST pain?**

\_\_\_ Morning, on arising      \_\_\_ Bedtime

\_\_\_ Later in the morning      \_\_\_ Night, during usual sleeping hours

\_\_\_ Afternoon      \_\_\_ Pain is always the same

\_\_\_ Evening      \_\_\_ Pain varies, but is not worse at any particular time

**16. Please indicate (with an "X") if the following; 'Increases', 'Decreases', or causes 'No Change' to your pain:**

<b>Stimulus/Treatment</b>	<b>Increase Pain</b>	<b>Decrease Pain</b>	<b>No Change</b>
SITTING			
STANDING			
HEAT			
COLD			
PHYSICAL ACTIVITY			
RELAXATION			
SLEEP			
LYING DOWN			
SEXUAL INTERCOURSE			
WEATHER CHANGES			
SNEEZING/COUGHING			
PHYSICAL THERAPY			
MASSAGE THERAPY			
CHIROPRACTIC THERAPY			
URINATION			
BOWEL MOVEMENT			
TENSION			
FATIGUE			
MEDICINE			
ALCOHOL			
OTHER			

**FUNCTIONAL SCORES**

**17. Please rate your ability to COPE with your pain (0= Not Capable, 10= Very Capable).**

0    1    2    3    4    5    6    7    8    9    10

**18. Please rate your ability to perform your ACTIVITIES OF DAILY LIVING, such as hygiene, household chores, transportation, ect. (0= Not Capable, 10= Very Capable).**

0    1    2    3    4    5    6    7    8    9    10

**19. Please rate the ability to FUNCTION AND INTERACT well with family and friends (0= Not Capable, 10= Very Capable).**

0    1    2    3    4    5    6    7    8    9    10

**20. Please rate your ability to WORK in your usual occupation (0= Not Capable, 10= Very Capable).**

0    1    2    3    4    5    6    7    8    9    10

**21. Do your pain medications provide relief?  YES  NO  I do not take pain medications IF 'YES,' how much improvements in function do you receive?**

0%    10%    20%    30%    40%    50%    60%    70%  
 80%    90%    100%

**22. Do you pain medication improve function?  YES  NO  I do not take pain medications IF 'YES,' how much improvements in functions do you receive?**

0%    10%    20%    30%    40%    50%    60%    70%  
 80%    90%    100%

**23. Do your pain medications improve your quality of life?  YES  NO  I don't take pain medications IF 'YES,' how much improvement in the quality of your life do you receive?**

0%    10%    20%    30%    40%    50%    60%    70%  
 80%    90%    100%

**24. If you take pain medication(s), how many hours does the pain relief last before the pain returns?**

<input type="checkbox"/> Pain medication doesn't help at all	<input type="checkbox"/> Six to eight hours
<input type="checkbox"/> One to two hours	<input type="checkbox"/> Nine to twelve hours
<input type="checkbox"/> Three to four hours	<input type="checkbox"/> More than twelve hours
<input type="checkbox"/> Five to six hours	<input type="checkbox"/> I don't take pain medication

**25. I prefer to take my pain medication:**  On a regular basis  Only when necessary  
 Do not take pain medication

**26. Do you feel you need a stronger type of pain medication?**  YES  NO   
Uncertain

**27. In a 24 hour period, I take my pain medication:**

Not every day  3 to 4 times per day  More than 6 times per day  
 1 to 2 times per day  5 to 6 times per day  I do not take pain medication

**28. Do you feel you need a stronger type of pain medication?**  YES  NO  Uncertain

**29. Do you feel you need to take more of the pain medication than your doctor prescribed?**

YES  NO  Uncertain

**30. Please indicate any side effects caused by your pain medications**

Nausea  Vomiting  Constipation  Upset Stomach  Sedation  
 Rash  Dizziness  Acid Reflux  Itching  No Side Affects

OTHER; \_\_\_\_\_

**31. Other methods I use to relieve my pain include; (Please list ALL that apply)**

Warm compresses  Relaxation techniques  Hypnosis  Cold compresses

Biofeedback  Distraction  OTHER \_\_\_\_\_

### **32. PAIN MEDICATION HISTORY**

**Please check all medications that you have tried in the past**

#### **Opiates:**

- Fentanyl (Actiq-Fentora Durgesic patch)       Demerol  
 Tramadol (Ultram; Ultram ER)       Hydrocodone (Lortab, Norco, Vicodin, Vicoprofen)  
 Morphine (Avinza, Kadian, Embeda, MS Contin)       Oxymorphone (Opana, Opana ER)  
 Methadone       Oxycodone (Percocet, Oxycontin)  
 Hydromorphone (Dilaudid, Exalgo)       Tapentadol (Nucynta)  
 Propoxyphene (Darvocet, Darvon)       Codeine (Codeine, Tylenol#3, Tylenol#4)  
 Buprenorphine (Suboxone', Subutex)

#### **Anti-inflammatories & Tylenol:**

- Diclofenac (Arthotec, Voltaren, Voltaren Gel)       Oxaprozin (Daypro)  
 Meloxicam (Mobic)       Nabumetone (Relaten)  
 Asprin       Indomethacin (Indocin)       Ibuprofen (Motrin, Advil)  
 Acetaminophen (Tylenol)       Celecoxio (Celebrex)  
 Etodolac (Lodine)       Naproxen (Naprosyn)       Flector Patch

#### **Muscle Relaxants:**

- Baclofen       Methocarbamol (Robaxin)       Carisoprodol (Soma)  
 Cyclobenzaprine (Flexeril, Amrix)       Metaxalone (Skelaxim)       Tizanidine (Zanaflex)  
 OTHER; \_\_\_\_\_

#### **Antidepressants:**

- Cymbalta       Nortriptyline (Pamelor)       Remeron       Wellbutrin  
 Effexar       Paxil       Serzone       Zoloft       Amitriptyline       Pristig  
 Imipramine (Tofranil)       Lexapro (Elavil)       Fluoxetine (Prozac)       Trazdone  
 OTHER \_\_\_\_\_

**32; Continued**

**Sleep Aids:**

Zolpidem (Ambien, Ambien CR)    Lunesta    Rozerem    Xyrem  
 Restoril    Sonata    OTHER \_\_\_\_\_

**Other Medications:**

Axert    Hydroxyzine    Lyrica    Zonegran    Buspar    Imitrex  
 Frova    Keppra    Maxalt    Clonazepam ( Klonopin)  
 Gapapentin (Neurontin)    Temazepam (Xanax)    Gabitril    Lidoderm patch  
 Relpax    OTHER \_\_\_\_\_

**33. Sleep Behavior:**

Do you have difficulty falling asleep?    YES    NO  
Do you have difficulty staying asleep?    YES    NO  
Are you ever awakened by your pain?    YES    NO

**Approximately how many hours do you sleep at night?**

1    2    3    4    5    6    7    8    9    10

**Complete Medical History:** In order to develop your individual plan of treatment, we need to gather detailed information about your past medical history, past surgical history, past psychological history, family history, and social history. Please answer the following questions accurately and honestly. Use the back of this form if more space is needed.

**34. Are you pregnant?**    YES    NO

**35. Have you been diagnosed with the following? (Please check all that apply)**

Asthma    Fibromyalgia    Liver disease    Psoriasis    Cancer  
 Heart Disease    Lupus    Shingles    Diabetes    Hepatitis (A, B, C, D)  
 Migraine Headaches    Stroke    Emphysema    High Blood Pressure  
 Osteoarthritis    Tuberculosis    Epilepsy/Seizure Disorder    Hypothyroidism  
 Hyperthyroidism    Peripheral Vascular Disease    OTHER \_\_\_\_\_

**36. Past Surgical History: Please list all prior surgeries or procedures in the table below**

Date	Surgery/Procedure	Physician	Location

**37. Medications: Please indicate if you are taking any of the following blood-thinning medications**

Aggrenox (aspirin and dipyridamole)     Ginko or Ginko Bilboa  
 Plavix (clopidogrel bisulfate)     Aspirin     Heparin     Pletal (Cilostazol)  
 Coumadin (Warfarin)     Lovenox (enoxaparin)     Ticlid (Ticlopidine)  
 OTHER \_\_\_\_\_

**Allergies:**

**38. If you are allergic to any medications, foods (e.g. Shellfish), or topical or intravenous agents (e.g. tape, Iodine, latex gloves), Please List them, the reaction, and severity in the table below.**

Medication/Agent	Reaction	Severity

**Social History:**

**39. Do you smoke?**     Yes, currently     Yes, in the past     No, never

If "YES currently", how long have you smoked?    Years: \_\_\_\_\_    Months: \_\_\_\_\_

If "YES, currently", how many packs per day?     0-1/2     1/2 -1     1-2     More than 2

If "YES, in the past", When did you quit? \_\_\_\_\_

**40. Do you use alcohol?  YES  NO, IF "YES" how many drinks do you consume? (Answer only 1 of the options below).**

I consume \_\_\_\_\_ drinks \_\_\_ day \_\_\_ week \_\_\_ month

**41. Have you ever had a problem with prescription medications (misuse, abuse, addiction)?**

Yes, currently  Yes, in the past  No, never

**42. Have you ever had a problem with illegal drugs (cocaine, marijuana, intravenous drugs, ect)?**

Yes, currently  Yes, in the past  No, never

**43. Have you ever been treated for addiction for alcoholism?  YES  NO**

**IF "YES", what treatment have you received? \_\_\_\_\_**

**44. Marital Status:**  Single  Married  Divorced  Widow/Widower

**45. Review of Systems: Please indicate whether you are experiencing any of the following symptoms, problems, or medical conditions.**

**GENERAL**

Decreased appetite  YES  NO Unexpected weight loss  YES  NO

Unexpected weight gain  YES  NO Fatigue  YES  NO

Fever  YES  NO Chills  YES  NO Night sweats  YES  NO

**ENDOCRINE**

Diabetes  YES  NO Hypothyroid (low thyroid)  YES  NO

Hyperthyroid (high thyroid)  YES  NO

**GASTROINTESTINAL**

Heartburn/Reflux  YES  NO Nausea/Vomiting  YES  NO

Abdominal Pain  YES  NO Abdominal pain  YES  NO

Irregular bowel habits  YES  NO Loss of control of bowels  YES  NO

Jaundice  YES  NO Gallstones  YES  NO Cirrhosis  YES  NO

Hepatitis (A, B, C, other)  YES  NO Pancreatitis  YES  NO

**45; Continued**

**Psychiatric**

Hallucinations \_\_\_ YES \_\_\_ NO Depression \_\_\_ YES \_\_\_ NO

Suicidal thoughts \_\_\_ YES \_\_\_ NO Homicidal thoughts \_\_\_ YES \_\_\_ NO

Have you ever had treatment for ANY of the above? \_\_\_ YES \_\_\_ NO > If "YES", for what diagnosis? \_\_\_\_\_ and what treatment have you received? \_\_\_\_\_

**SKIN**

Rash \_\_\_ YES \_\_\_ NO Itching \_\_\_ YES \_\_\_ NO Sores/Lesions \_\_\_ YES \_\_\_ NO

Unusual hair loss \_\_\_ YES \_\_\_ NO

**EYES**

Visual Changes \_\_\_ YES \_\_\_ NO Blind field of vision \_\_\_ YES \_\_\_ NO

Cataracts \_\_\_ YES \_\_\_ NO

**EAR/NOSE/THROAT**

Hearing loss \_\_\_ YES \_\_\_ NO Ringing \_\_\_ YES \_\_\_ NO

Sore throat/Hoarseness \_\_\_ YES \_\_\_ NO Sinusitis/Sinus drainage \_\_\_ YES \_\_\_ NO

**NEUROLOGIC**

Headaches \_\_\_ YES \_\_\_ NO Memory changes/loss \_\_\_ YES \_\_\_ NO

Numbness \_\_\_ YES \_\_\_ NO Weakness \_\_\_ YES \_\_\_ NO Seizure \_\_\_ YES \_\_\_ NO

Stroke \_\_\_ YES \_\_\_ NO

**MUSKOSKELETOL**

Joint pain/Arthritis \_\_\_ YES \_\_\_ NO Back/Neck pain \_\_\_ YES \_\_\_ NO

Muscle Aches \_\_\_ YES \_\_\_ NO

**Respiratory/Lungs**

Sleep apnea/CPAP Mask \_\_\_ YES \_\_\_ NO Persistent cough \_\_\_ YES \_\_\_ NO

Shortness of breath \_\_\_ YES \_\_\_ NO

**45; Continued**

**Cardiovascular**

Chest pain/Angina \_\_\_ YES \_\_\_ NO      Coronary artery disease \_\_\_ YES \_\_\_ NO

High blood pressure \_\_\_ YES \_\_\_ NO      Swelling in feet/legs \_\_\_ YES \_\_\_ NO

Abnormal Heart Rhythm \_\_\_ YES \_\_\_ NO

**Blood/Lymph**

Anemia \_\_\_ YES \_\_\_ NO      Bruising easily \_\_\_ YES \_\_\_ NO

Past blood transfusions \_\_\_ YES \_\_\_ NO      Bleeding disorder \_\_\_ YES \_\_\_ NO

Swollen/Tender lymph-nodes \_\_\_ YES \_\_\_ NO

**Renal/Urinary/Kidney**

Renal failure/insufficiency \_\_\_ YES \_\_\_ NO      Electrolyte deficiency \_\_\_ YES \_\_\_ NO

Kidney Stones \_\_\_ YES \_\_\_ NO      Painful urination \_\_\_ YES \_\_\_ NO

Difficulty urination \_\_\_ YES \_\_\_ NO      Urinary Tract Infection \_\_\_ YES \_\_\_ NO

Enlarged Prostate \_\_\_ YES \_\_\_ NO      Interstitial Cystitis \_\_\_ YES \_\_\_ NO

**Gynecologic**

Currently pregnant \_\_\_ YES \_\_\_ NO      Endometriosis \_\_\_ YES \_\_\_ NO

Heavy periods \_\_\_ YES \_\_\_ NO