Dallas Women's Healthcare Specialists, PLLC

MonaLisa Touch Internal Treatment Patient Questionnaire

Date: _____

Patient's Name: _____Patient's DOB:_____

Pre-Treatment # __1 __2 __3 __4 __5 __6

Follow up visit:____ weeks/months after last treatment

Please indicate the level of discomfort you are experiencing for each category below (rate 0-10)					
0	2	4	6	8	10
Very happy, no hurt	Hurts just a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts as much as you can imagine
					

Pain (0-10) _____	**Vaginal burning** (0-10) ___
Vaginal itching (0-10) ___	**Vaginal dryness** (0-10) ___
Painful sexual intercourse (Dyspareunia) (0-10) ____	**Painful urination (Dysuria)** (0-10) ____

Comments:_____

_____

_____

_____

Signature: _____