Dr Gary Groenewald
Gynaecologist • Obstetrician • Endoscopic Surgeon

Alma Lasers™
Wellbeing Through Technology

Date: _____ Patient ID: _____

Name: _____

D.O.B: _____

Why am I filling this questionnaire? To ensure that the doctor has adequate information about you to decide whether the Femilift Treatment is appropriate for you.

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|---|---|---|
| 1. Your reason for seeking Femilift Treatment? (can tick more than one option) | | ☐ Vaginal tightening ☐ Urinary leakage ☐ Vaginal dryness ☐ Other |
| 2. If you suffer from vaginal looseness, how long have you felt this way? | | |
| 3. How many children have you given birth to? | | |
| 4. How many were born vaginally? | ☐☐ | |
| 5. Did you receive any episiotomy cuts or bad tears? | ☐☐ Y N | |
| 6. Are you pregnant or think you may be pregnant? | Y ☐ N ☐ ☐☐ | |
| 7. Are you planning to have any children in the future? | Y N | |
| 8. Are you breast feeding? | Y N ☐☐ | |
| 9. When was the date of your last menstrual cycle? | ☐☐ | |
| 10. Do you regularly experience superficial pain near the entrance of the vagina on penetration? If so, how long has this been happening? | Y N ☐☐ | |
| 11. Do you regularly experience deep pain in your pelvis during penetrative intercourse? If so, how long has this been happening? | Y N ☐☐ | |
| 12. Do you have to use any kind of lubrication during intercourse? | Y N ☐☐ | |
| 13. Do you generally experience vaginal dryness (unrelated to sexual intercourse)? | Y N ☐☐ | |
| 14. Have you experienced any vaginal bleeding following intercourse in the past 1 year? | Y N ☐☐ | |
| 15. Are you prone to cystitis type symptoms after intercourse? | Y N ☐☐ | |
| 16. Have you been diagnosed to have a sexually transmitted infection in the last 2 years? | Y N | |

| | | |
|---|---|---|
| 17. Do you regularly suffer from vaginal thrush? | Y N | |

| | | |
|---|---|---|
| 18. Have you ever suffered from genital herpes? | Y N | |
| 19. Have you had a hysterectomy? | Y N | |
| 20. Have you had any vaginal repair surgery for prolapse? | Y N | |
| 21. Have you had any surgery to correct incontinence? | Y N | |
| 22. Have you recently had any gynaecological treatments or surgery? | Y N | |
| 23. Are you using aspirin or any blood thinning medication? | Y N | |
| 24. Do you take any prescribed or non prescribed medication or herbal remedies? (eg St Johns wart) | Y N | |
| 25. Do you have any allergies? | Y N | |
| 26. Do you have any general medical history? (eg epilepsy, diabetes, hypertension) | Y N | |
| 27. Do you have any type of immune deficiency? (eg HIV or Hepatitis) | Y N | |