THEODORE V. BENDEREV, M.D.   KYM A. KANALY, M.D.   PATRICIA A. WALLACE, M.D.

LEGAL NAME - FIRST: ____________ LAST: ____________ MI: ______

STREET, CITY, ZIP: ____________

HOME PHONE: (   ) ____________ CELL: (   ) ____________ EMAIL: ____________

SOCIAL SECURITY: ____________ DATE OF BIRTH: ____________ GENDER: F M

EMPLOYER: ____________ JOB TITLE: ____________

WORK PHONE: (   ) ____________ ☐MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

YOUR PRIMARY CARE PHYSICIAN: ____________ PHONE: (   ) ____________

WHO REFERRED YOU TO OUR OFFICE: ____________

ADDRESS, CITY, STATE, ZIP: ____________

LEAVE BLANK IF YOU DO NOT WISH TO REPORT THE FOLLOWING: PREFERRED LANGUAGE: ____________

NATIONALITY (CITIZENSHIP): ____________ ETHNICITY: ____________ RACE: ____________

REQUIRED TO FILL PRESCRIPTIONS: *(IF LEFT BLANK WILL DEFAULT TO TOWER PHARMACY)*

PHARMACY NAME: ____________ PHONE: (   ) ____________

ADDRESS, CITY: ____________ FAX: (   ) ____________

PLEASE BRING YOUR INSURANCE CARD AND DRIVER'S LICENSE TO YOUR APPOINTMENT.
IF YOU DO NOT HAVE PROOF OF INSURANCE - PAYMENT IS REQUIRED
AT THE TIME SERVICE IS RENDERED. WE CAN MAKE NO EXCEPTIONS.

RESPONSIBLE PARTY (OTHER THAN PATIENT)

FIRST NAME: ____________ LAST: ____________ MI: ______

RELATIONSHIP TO PATIENT: ____________ DRIVERS LICENSE #: ____________

DATE OF BIRTH: ____________ EMPLOYER: ____________

EMERGENCY CONTACT

NAME: ____________ PHONE : (   ) ____________

RELATIONSHIP TO PATIENT: ____________

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE THE INCONTINENCE & PELVIC SUPPORT INSTITUTE (IPSI) TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I HEREBY AUTHORIZE IPSI TO ACCESS, COMMUNICATE AND MAINTAIN MY MEDICATION HISTORY ELECTRONICALLY THROUGH ESCRIBE AND/OR OTHER ELECTRONIC PRESCRIPTION SERVICES IN CONNECTION WITH MY MEDICAL TREATMENT AND IN COMPLIANCE WITH HIPAA REGULATIONS.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. FOR ANY BALANCES OVER 45 BUSINESS DAYS OUTSTANDING, I UNDERSTAND THERE MAY BE A $5.00 MONTHLY FEE FOR BILLING SERVICE, PLUS INTEREST. A PHOTOCOPY OR SCANNED COPY OF THIS ASSIGNMENT AND RELEASE IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNED: (PATIENT OR PARENT IF MINOR): ____________

DATE: ____________

THEODORE V. BENDEREV, M.D.   KYM A. KANALY, M.D.   PATRICIA A. WALLACE, M.D,

FINANCIAL POLICIES

We welcome you to our office. We are able to concentrate on the practice of medicine and provide quality care by having our financial policies understood by our patients and by avoiding confusion or misunderstandings.

Filing insurance claims is a courtesy extended to our patients and is not a guarantee of payment. We will bill insurance claims with a maximum of two insurance carriers per patient. It is important to emphasize that your insurance is a contract between you and the insurance carrier. Insurance plans and contracts change constantly. It is your responsibility to contact your insurance company and verify your benefits and verify that your doctor is a contracted provider in your network PRIOR to your visit. You will be financially responsible for the services rendered if we have not been paid by your insurance carrier within 45 business days.

_________ **(patient's initials)**

Drs. Benderev, Kanaly and Wallace are participating physicians with Medicare and accept assignment for all covered Medicare services. Medicare pays 80% of approved charges and the patient is responsible for the other 20%, after the annual deductible is met. Our office staff will bill secondary insurance if the responsible party has given permission to the insurance company to have the payment sent to us. Each physician reserves the right to accept Medi-Medi and accept the Medicare payment portion as payment in full.

Drs. Benderev, Kanaly and Wallace are not participating physicians with Medi-Cal and therefore, cannot accept Medi-Cal insurance (including retro-active Medi-Cal coverage). For patients without insurance plans or for patients that are unable to provide an insurance card verifying current coverage, we require payment at the time services are rendered. If you do not have insurance or your insurance company does not pay for services rendered it is the patient's responsibility for payment in full. This also applies to patients requesting services that have insurance plans with which we are not contracted, (e.g., out-of-network coverage).

_________ **(patient's initials)**

All services rendered by Drs. Benderev, Kanaly and Wallace that are not a covered benefit of your insurance policy are your responsibility to pay. Any patient that is seen or treated without proper authorization from their insurance carrier is responsible for the full charge of the services rendered if no payment is authorized retrospectively. All monies owed by the patient (e.g. co-payments, deductibles, required "out-of-pocket" amounts, non-covered services and co-insurance amounts) are due at the time services are rendered.

_________ **(patient's initials)**

If your account is placed with a collection agency, due to non-payment, you will be responsible for any additional charges this may incur, including a monthly interest and penalty fee, collection agency fees, attorney fees, court fees, and any other fees associated in collecting the balance due.

_________ **(patient's initials)**

While we understand there may be times when our patients need to cancel their appointments, we have found it necessary to implement a "Cancellation and No-Show Policy". Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show." A no-show patient scheduled for an office visit may be charged $40.00. A no-show patient scheduled for a procedure or diagnostic test may be charged $100.00. No-show charges are not billable to your insurance company and are your responsibility to pay.

_________ **(patient's initials)**

We are willing to work with any patient requesting a financial payment plan. <u>There will be a $45 charge for each check that is returned for insufficient funds.</u>

We hope you find this information helpful. Please feel free to ask our office staff if you require any further assistance.

Patient Signature: ___________________________________ **Date:**________________________

Theodore V. Benderev, M.D. Kym A. Kanaly, M.D. Patricia A. Wallace, M.D.
26732 Crown Valley Parkway, Suite 327 * Mission Viejo * CA * 92691 * 949.364.4400

PRIVACY PRACTICES ACKNOWLEDGEMENT

NOTE: A copy of our Privacy Practices Policy is available upon request.

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Name ______________________________ **Birth Date** ________________

Signature ___________________________ **Date** ______________________

NOTE: This request supersedes any prior request I may have made for confidential patient record disclosures.

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner (check all that applies):

☐ Home Telephone _______________ ☐ Email Address ___________________________

- ☐ O.K. to leave detailed message, including clinical information with spouse, family member, and/or on voicemail.
- ☐ Leave message with call back number only.

☐ Cell Telephone __________________

- ☐ O.K. to leave detailed message, including clinical information with spouse, family member, and/or on voicemail.
- ☐ Leave message with call back number only.

☐ Work Telephone _______________

- ☐ O.K. to leave detailed message, including clinical information with spouse, family member, and/or on voicemail.
- ☐ Leave message with call back number only.

NOTE: Uses and disclosures of health information may be permitted without prior consent in an emergency.

ADVANCED CENTER FOR PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY
OC Sexual and Pelvic Wellness
Patricia A.Wallace, M.D.
Kym A. Kanaly, M.D.

Patient Name: ______________________ Date: ______________

Reason for visit today: ____

If you have specific GYN issues you would like addressed, please check all issues that apply to you.

Sexual Complaints
__decreased libido __problems with orgasm __pain with sexual activity __vaginal dryness

Vaginal Complaints
__vaginal itching __vaginal pain __vaginal dryness __recurrent vaginal infections __lichen sclerosis

Vulvar Complaints
__vulvar sore __vulvar pain

Urinary Complaints/Pelvic Complaints
__burning with urination __increased urinary frequency __increased urinary urgency __vaginal bulging
__urinary incontinence (leaking) __recurrent urinary tract infections __interstitial cystitis

Other
__abnormal PAP __birth control __sexually transmitted disease __genital herpes

Other GYN-related issue(s), not listed above:

____

____

FEMALE MEDICAL HISTORY

Please circle any illnesses that you have:

[ ] **I have no medical problems**
Alcoholism
Alzheimer's Disease
Anxiety
Arthritis
Asthma
Attention Deficit Hyperactivity Disorder
Bleeding Disorders
Cancer , Type:
____
Cerebrovascular Accident (Stroke)

Cervical Disc Herniation
Chronic Cough
Deep Vein Thrombosis
Depression
Diabetes
Fibromyalgia
Gastroesophageal Reflux Disease
Glaucoma
Heart Disease
Hepatitis
Hyperparathryoidism

Hypothryoidism
Lumbar Disc Disorders
Multiple Sclerosis
Myocardial Infarction (MI)
Parkinson's Disease
Renal Stones
Rheumatic Fever
Spinal Cord Injury
Other medical problem(s), Type:
____

SURGICAL HISTORY

Please circle any surgeries that you have had:

Abdominal Hysterectomy
Abdominal Surgery, Type:
____
Appendectomy
Back Surgery
Bladder Suspension
CABG X_______vessels
Cervical Conization/LEEP
Cystocele (urinary bladder) Repair
Dilation/Curettage

Cholecystectomy (removal of the gall bladder)
Endometrial Ablation
Facial Surgery, Type:
____
Hip Surgery
Knee Surgery
Laparoscopy
Labial Surgery
Mastectomy on _______side
Vaginal Surgery

Sling Procedure
Tonsillectomy
Unilateral/Bilateral Salpingo-oophorectomy (removal of ovaries)
Vaginal Hysterectomy
Any Other Surgery, Type:
____
____

Patient Name:____ Date:______________________________

MEDICATIONS

Name	Dosage (e.g. mg, gm, cc)	When during day	When started

ALLERGIES: (include medications, iodine, seafood and latex)

REACTION

____

____

____

____

FAMILY HISTORY Please indicate illnesses these family members have had:

Maternal (Mother) Side:______________________ Son:______________________

Paternal (Father) Side:______________________ Sister:______________________

Daughter:______________________ Brother:______________________

Adopted: Yes No

SOCIAL HISTORY Please circle or fill out the appropriate answer(s):

Marital Status: Single Married, happily – Yes No Separated Divorced Remarried Widowed

Number of Children: From this marriage:__________ From any prior marriage:__________

Employment: Vocation:______________________ Employed Unemployed Retired Student

Tobacco: Has never smoked

Quit smoking: less than 5 years ago 5 to 10 years ago more than 10 years ago

Number of Years using tobacco__________ Number of Cigarettes per day: 1 5 10 20 30 40

Frequency of Drinks (alcohol): Never drinks Drinks rarely Drinks per day: 1 2 more than 2

Use of Illicit Drugs: Never In the past only Currently

HEALTH MAINTENANCE

	Colonoscopy	Bone Density	Health Screen Lab Tests	Pap Smear	Mammogram
Month and Year of Last:	__________	__________	__________	__________	__________

Menstrual History:

Last Menstrual Period (LMP):__________

Normal Menses Yes No

Severity of Menstruation Light Normal Heavy

Menopause Yes No

Birth Control Method: Natural, Barrier, Implant, IUD, Vaginal Ring, Injectable, Tubal Ligation, Oral Contraceptive, Vasectomy

Pregnancy History:

Number of Pregnancies: __________

Number of Vaginal Deliveries: __________

Number of C-Section Deliveries: __________

Largest Birth Weight: __________pounds

[ ] delivered with forceps

[ ] delivered by vacuum

Patient Name:____Date:______________________________

REVIEW OF SYSTEMS: Please **circle** all symptoms that you **currently** have:

Constitutional
Chills
Fever
Weight Gain

Eyes
Blurred Vision
Double Vision

Earn/Nose/Throat/Neck
Dry Mouth
Hearing Loss
Sore Throat

Cardiovascular
Chest Pain
Palpitations
Edema (swelling), location:
____

Respiratory
Cough
Dyspnea
Dry Cough
Productive Cough

Gastrointestinal
Anorexia
Heartburn
Abdominal Pain
Nausea
Vomiting
Constipation
Diarrhea
Fecal Urgency
Incontinence of Stool
Rectal Bleeding
Black Stool

Genitourinary/Nephrology
Dysuria (burning with urination)
Hematuria (blood in urine)
Urinary Incontinence
Pain with intercourse (dyspareunia)
Vaginal Dryness

Musculoskeletal
Joint aches (arthralgias)
Back Pain
Gait abnormality (difficulty walking)
Hip Pain
Myalgias (muscle ache)
Neck Pain

Dermatologic
Rash, location:_______________

Neurologic
Confusion
Dizziness
Headaches
Impaired Balance
Memory Loss
Numbness, location:_______________
Parasthesias (funny feeling on your skin) location:____________________

Psychiatric
Anxiety
Depression

Endocrine
Alopecia (loss of hair), location:
____
Change in sex drive (libido)
Drinking large amounts of fluids (polydipsia)

Hematologic
Easy Bleeding
Easy Bruising

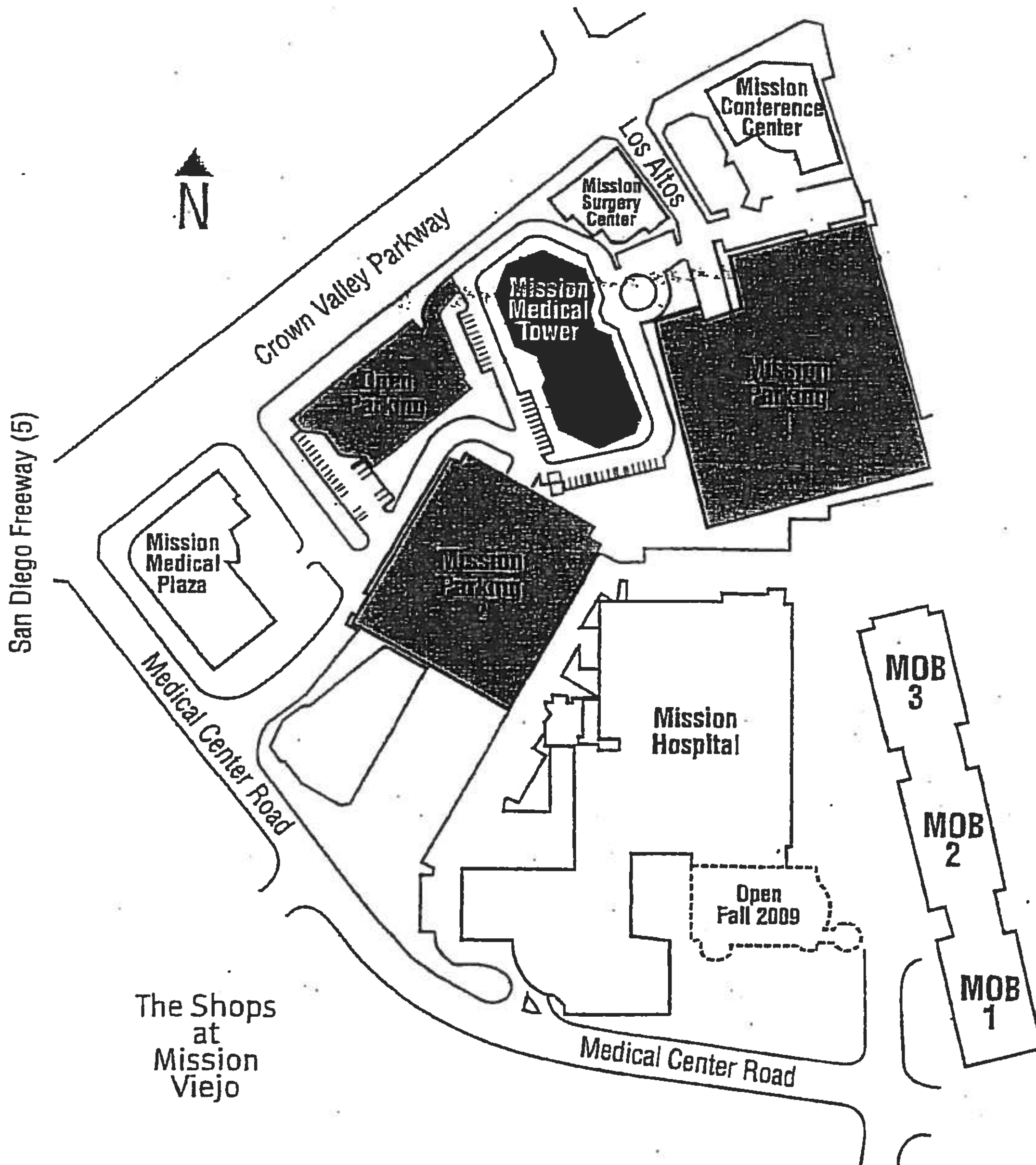
Allergy/Immunology
Nasal Drainage

Do you have a pacemaker, defibrillator, or mechanical heart valves? Yes No

We are located at

26732 Crown Valley Pkwy
Suite # 327
Mission Viejo, CA
92691

Phone 949 364-4400



Mission Campus Map

Theodore V. Benderev, M.D.

Patricia A. Wallace, M.D.

Kym A. Kanaly, M.D.

Telephone Extensions to Help Our Patients Navigate Our Phone System

Phone number: **949.364.4400**

ONCE THE GREETING BEGINS SELECT ONE OF THE FOLLOWING EXTENSIONS:

APPOINTMENT SCHEDULING/RECEPTION – select **101 OR 102**

MEDICAL ASSISTANT or for **REFILLS** and **TEST RESULTS** select **107**

SURGERY SCHEDULER and **AUTHORIZATON SPECIALIST**, select **104**

MEDICAL RECORD SPECIALIST, select **103**

BILLING OFFICE, select **949.436.0014**

MANAGER/ADMINISTRATION select **106**

Please leave a message if your party does not answer. Be sure to leave your full name, date of birth and a phone number where you can be reached.

Messages received before 4:30 pm Monday – Thursday will be returned before the close of the business day. Our office closes at 1:30 on Fridays. Messages received before 1:00 pm on Friday, will be returned before the close of the business day.

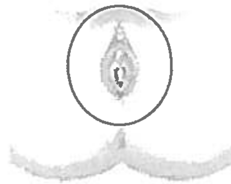
THERMIva Pre-Treatment Instructions

HISTORY

- It is recommended to have a normal physical and pap smear within 2 years.
- If you have frequent urinary tract infections, it may be required by your provider to complete a urinalysis prior to the procedure.
- Let your physician know if you are prone to herpes outbreaks, as your provider may want to prescribe an antiviral prior to the treatment.
- Inform your physician of any vaginal surgery or if you have been told you have any vaginal prolapse.

ACTIVITY

- A negative pregnancy test may be required for women of childbearing age.
- Empty bladder immediately before treatment.
- Shave the external treatment area (see diagram) at least one day prior to the procedure (Waxing or laser hair removal 5-7 days prior to avoid further irritation).



- Menstruating is not contraindicated. However, if you are in the middle of a heavy flow, you may want to reschedule for your own comfort.

CONTRAINDICATIONS

- Cardiac devices such as AICD's (auxiliary internal cardiac devices), defibrillators, mechanical valves, pacemakers, or any device that is affected by RF energy.
- Pregnancy
- Active sexually transmitted disease
- Current urinary tract infection
- Greater than a stage 2 pelvic organ prolapse
- Recent vaginal surgery or fillers may require an alternative treatment

- One month after each treatment. Total of three treatments.

** This pre-treatment checklist is for reference only. It is not all inclusive of individual practices' guidelines and requirements for a patient's history, physical, and clinical judgement for treatment.*

THERMIva®

Patient Name: ______________________ Date: ____________

Date Of Birth: ______________________

Pre-Treatment Questionnaire

Question		1	2	3	4	5	
Please rate your vaginal laxity:	Very Loose	1	2	3	4	5	Very Tight
Please rate your sexual satisfaction from vaginal intercourse:	Extremely Dissatisfied	1	2	3	4	5	Extremely Satisfied
Please rate your ability to climax/orgasm:	Never	1	2	3	4	5	Always
Please rate your vaginal moisutre during sexual activity:	Very Dry	1	2	3	4	5	Very Moist
How would you rate your ability to control urine when you cough?	No Control	1	2	3	4	5	Excellent Control
How successful are you with controlling your stream of urine (start and stop)?	No Control	1	2	3	4	5	Excellent Control
How often do you feel urinary urgency (feeling that you have to go to the bathroom)?	No Control	1	2	3	4	5	Excellent Control

Please describe your present state of feminine health and wellness:

Female Sexual Function Index (FSFI) ©

Patient Name
Subject Identifier ________________________ Date ________________

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

CHECK ONLY ONE BOX PER QUESTION.

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?

   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?

   - ☐ Very high
   - ☐ High
   - ☐ Moderate
   - ☐ Low
   - ☐ Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Very high
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Very low or none at all

5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Very high confidence
- ☐ High confidence
- ☐ Moderate confidence
- ☐ Low confidence
- ☐ Very low or no confidence

6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

8. Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

9. Over the past 4 weeks, how often did you **maintain** your lubrication ("wetness") until completion of sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?

☐ No sexual activity
☐ Almost always or always
☐ Most times (more than half the time)
☐ Sometimes (about half the time)
☐ A few times (less than half the time)
☐ Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?

☐ No sexual activity
☐ Extremely difficult or impossible
☐ Very difficult
☐ Difficult
☐ Slightly difficult
☐ Not difficult

13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

☐ No sexual activity
☐ Very satisfied
☐ Moderately satisfied
☐ About equally satisfied and dissatisfied
☐ Moderately dissatisfied
☐ Very dissatisfied

14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

☐ No sexual activity
☐ Very satisfied
☐ Moderately satisfied
☐ About equally satisfied and dissatisfied
☐ Moderately dissatisfied
☐ Very dissatisfied

15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

17. Over the past 4 weeks, how **often** did you experience discomfort or pain <u>during</u> vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain <u>following</u> vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Very high
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Very low or none at all

Thank you for completing this questionnaire

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Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ-12)

DATE: ____________________

NAME: ______________________________________ **DATE OF BIRTH:** ________________

Instructions: Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your answers will be used only to help doctors understands what is important to patients about their sex lives. Please check the box that best answers the question for you. While answering the questions, consider your sexuality over the past **six months**. Thank you for your help.

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.
   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?
   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
3. Do you feel sexually excited (turned on) when having sexual activity with your partner?
   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
4. How satisfied are you with the variety of sexual activities in your sex life?
   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
5. Do you feel pain during sexual intercourse?
   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
6. Are you incontinent (leak urine) with sexual activity?
   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?
   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
8. Do you avoid sexual intercourse because of bulging in the vagina (either bladder, rectum or vagina falling out)?
   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?
   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
10. Does your partner have a problem with erections that affects your sexual activity?
    ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?
    ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)
12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?

    ☐ Much less intense (4) ☐ Less intense (3) ☐ Same intensity (2) ☐ More intense(1) ☐ Much more intense (0)