THERMIva®

Patient Name: _____ Date: _____

Date Of Birth: _____

Pre-Treatment Questionnaire

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: