1765 S. Springdale Rd Cherry Hill NJ 08003 www.hughescenter.net (856)751-4554

Age:	Date of last PAP smear:	
Onset of menopause (natural or induced):		
Menses within the past year	NO	YES
Itchiness and burning sensation	NO	YES
Discomfort related to vaginal laxity • without a pelvic organ prolapse • with a pelvic organ prolapse	 NO NO	 YES YES: ≤ POP-Q Stage 1 ☐ ≥ POP-Q Stage 2 ☐
Decreased vaginal lubrication	NO	YES
Sexually active	NO	YES
Pain during sexual intercourse	NO	YES
Bleeding during sexual activity	NO	YES: frequency?
Atypical vaginal /uterine bleeding	NO	YES: frequency?
Thick, whitish or yellowish vaginal discharge	NO	YES
Hysterectomy	NO	YES: when?
Pelvic floor surgery	NO	YES: when?
History of oestrogen therapy	NO	YES: outcome?
Stress urinary incontinency	NO	YES: during... Sneeze/Cough/Laugh ☐ Exercise/Heavy object lifting ☐
Stinging during urination	NO	YES
Medical history of cancer	NO	YES: what ? when?
Systemic disease	NO	YES: what?
Medical history of genital infections	NO	YES: what ? when?
Medical history of urinary tract infection	NO	YES: when?
List of additional current medication taken		

My signature certifies that I have duly read and understood the content of this informed consent form, and gave the accurate information as to my health condition. I hereby freely consent to the AcuPulse® FemTouch™ procedure

Name of patient (please print) Signature of patient Date

Name of witness (please print) Signature of witness Date

(1 copy Patient and 1 copy Physician for Medical Record)

CD-2003809 Rev A