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:

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Post-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 moisture 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 an abrupt, strong, often overwhelming urge to urinate?	**No Control**	1	2	3	4	5	**Excellent Control**

How would you rate your level of comfort during the procedure?

Please describe any changes in your feminine health and wellness since you received your treatment: