Mercier Therapy History and Evaluation Form

Name: _____ Date: _____/____/____ Age:_____

Birthdate: ___/____/_____ Profession:_____

Age of 1st Menses:_____ Last Menstrual Period:_____

Frequency of Periods: _____ Duration of Menses: _____

Current Medications: _____

Current Supplements: _____

Past History of Oral Contraceptives or IUD use: _____

Reason for seeking therapy: _____

_____

Current Ultrasound done: YES __ NO __Any abnormalities on ultrasound: _____

Any current discomfort or pain and where:_____

Is there any discomfort or pain during menstrual cycle and if so, when during the cycle is the pain noticed:_____

Past Pelvic or Vaginal infections: _____

History of Abortion: YES ____ No _____ Dates:_____

History of Miscarriage: YES _____ No _____ Dates: _____

Obstetric History:

Gravida (Number of pregnancies) _____ Parity (Number of live births) _____

Describe your births: Vaginal _____ C-Section _____ Dr. assisted_____ Medicated _____

Epidural _____ Natural / No drugs_____ Other: (describe) _____

Birth Trauma _____

Gynecologic Surgical History & Dates: _____

_____

Abdominal Surgical History: _____

Urinary Surgical History: _____

Reported Sexual Abuse: _____

Intestinal Problems: _____

Frequency of Bowel Movements: Daily ____ Weekly ____ Infrequent_____ Difficult to pass_____

_____

History of Assisted Reproductive Intervention: _____

_____