Mercier Therapy History and Evaluation

Name_____ Age_____

DOB_____ Profession _____

Menarche_____ LMP_____

Frequency of periods _____Duration of menses _____

Current Medications_____

Current Supplements_____

Past history of oral contraceptive or IUD use _____

Reason for seeking therapy_____

Current Gynecological Ultrasounds done?_____

Any abnormalities seen on ultrasound?_____

Current complaints of pelvic pain? _____

When during cycle is pain noted?_____

Past pelvic or vaginal infections: (if yes, how was it treated)

History of miscarriage or elective abortion: (give dates of occurrences)

Obstetric History- G P ☐vaginal ☐c-section Reported birth trauma:

Gynecological surgical history:

History of sexual abuse:

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Abdominal surgical history: (give dates and details)

Urinary surgical history: (give dates and details)

Intestinal problems:

Frequency of bowel movements:

Any blood noted in BM? ☐ yes ☐ no

History of IVF: (give dates and type of drug used, how many eggs retrieved, how many embryos transferred, outcome)

History of medically assisted fertility cycles: (dates, type of cycle, outcome)

(For Doctor Use Only):

Evaluation of general pelvic movement:

Position and mobility of uterus and ovaries:

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Comments:

Plan:

Supplements:

Practitioner Signature_____Date_____