Female Sexual Health Evaluation Form

Full Name

Age

Marital Status

Occupation

Relevant Medical History

Current Medications

Allergies

Menstrual History

Obstetric History

Do you experience any of the following?
☐ Pain during intercourse ☐ Vaginal dryness ☐ Low sexual desire ☐ Difficulty with arousal ☐ Difficulty achieving orgasm ☐ Other

When did these symptoms begin?

How often do the symptoms occur?

Severity of symptoms

Are you sexually active?
○ Yes ○ No

If yes, is it with:

Current relationship satisfaction

Any history of sexual trauma or abuse?

Yes No Prefer not to answer

Additional information or concerns