

Appointment Prep Summary

Fill this out at home before your appointment. Bring both pages to hand to your provider.

Name: _____

Date of appointment: _____ Provider / specialty: _____

Pain scale:	0	1	2	3	4	5	6	7	8	9	10
	none					moderate					severe

CURRENT SYMPTOMS & SEVERITY

Circle a number for each symptom you experience. Leave blank if not applicable.

Symptom	Severity – circle one (0 = none 5 = moderate 10 = severe)	How long?
Pelvic / bladder pain or pressure	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	
Urinary urgency	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	
Urinary frequency	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	
Pain with intercourse / activity	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	
Other: _____	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10	

What makes symptoms worse:

Certain foods/drinks Stress Sitting Exercise Intercourse Clothing Other: _____

What makes symptoms better:

Heat Rest Medication Movement Other: _____

DIAGNOSTIC HISTORY

Approx. date	Test, procedure, or diagnosis	Result / finding

CURRENT MEDICATIONS & SUPPLEMENTS

Medication / supplement	Dose & frequency	What it's for	Helpful? (Y / N / ?)



Scan to get Intero from the App Store

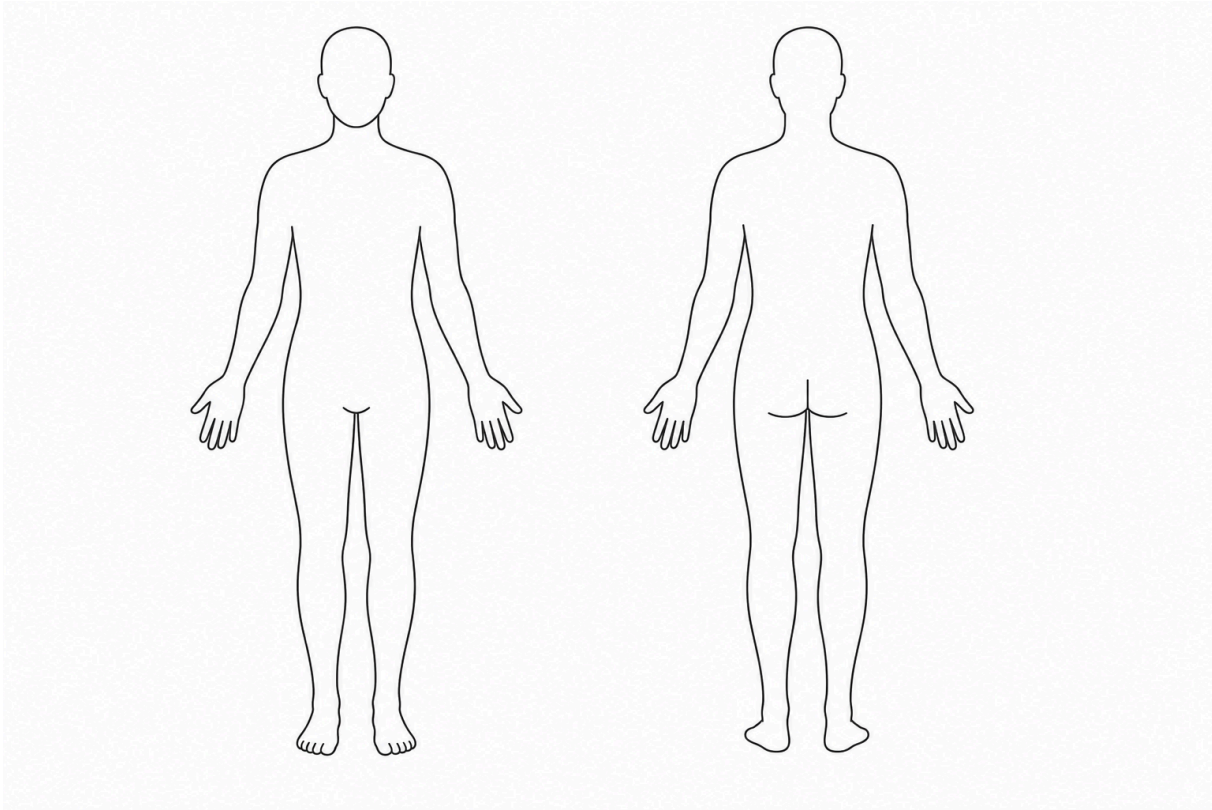
Intero

More copies and other symptom tracking worksheets: getintero.app/forms

Body Diagram

Shade or mark the areas where you feel pain, pressure, or discomfort.

Name: _____



Front

Back

Pain type — circle all that apply:

- Aching Burning Pressure Stabbing / sharp Cramping Other: _____

WHEN IS PAIN WORST?

- Morning Evening After eating After activity During / after intercourse When sitting No clear pattern

- Other: _____

ADDITIONAL NOTES FOR YOUR PROVIDER



Scan to get Intero from the App Store

Intero

More copies and other symptom tracking worksheets: getintero.app/forms