

HIFU Treatment Record Sheet

Patient Name: _____ MRN/ID: _____

Age: _____ Date: ____ / ____ / 20____

Session Number: 1 2 3 Maintenance

Treatment Parameters

Device Name/Model: _____

Probe/Transducer Depth Used (mm): 3.0 4.5 Other: _____

Mode Used: Linear Dot Pulsed

Energy Level (initial): _____ (adjusted if needed: Yes / No)

Vaginal Length Covered (cm): _____

Number of Passes: _____

External Labial Pass (if performed): Yes No Tip Used: _____

Patient Feedback During Treatment

Discomfort Level: None Mild Moderate Severe

Any adverse event during procedure: Yes No If yes, specify: _____

Post-Treatment Instructions Given

Feminine wash advised Avoid intercourse 3–5 days Avoid internal washing Follow-up after 4–6 weeks

Follow-Up (after 4–6 weeks)

Symptom Improvement: Yes No Partial Patient-reported score (if applicable): _____

Next session planned: Yes No Date: ____ / ____ / 20____

Clinician Name & Signature: _____ Date: ____ / ____ / 20____