



PATIENT HISTORY

Name: _____ Age: _____ Date: _____

1. Describe the current problem that brought you here: _____

2. When did your problem first begin? _____ months ago or _____ years ago

3. Was your first episode of the problem related to a specific incident? Yes / No
Please describe and specify date _____

4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how? _____

5. If pain is present rate pain on a 0-10 scale 10 being the worst _____ Describe the nature of the pain (i.e. constant burning, intermittent ache) _____

6. Describe previous treatment/exercises _____

7. Activities/events that cause or aggravate your systems. Check/circle all that apply.

<input type="checkbox"/> Sitting greater than _____ minutes	<input type="checkbox"/> With cough/sneeze/straining
<input type="checkbox"/> Walking greater than _____ minutes	<input type="checkbox"/> With laughing/yelling
<input type="checkbox"/> Standing greater than _____ minutes	<input type="checkbox"/> With lifting/bending
<input type="checkbox"/> Changing positions (i.e. - sit to stand)	<input type="checkbox"/> With cold weather
<input type="checkbox"/> Light activity (light housework)	<input type="checkbox"/> With triggers - running water/key in door
<input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump)	<input type="checkbox"/> With nervousness/anxiety
<input type="checkbox"/> Sexual activity	<input type="checkbox"/> No activity affects the problem
<input type="checkbox"/> Other, please list _____	

8. What relieves your symptoms? _____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify _____
Diet/Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

10. Rate the severity of this problem from 0-10 with 0 being no problem and 10 being the worst _____

11. What are your treatment goals/concerns? _____

Since the onset of your current symptoms have you had:

Y / N Fever/Chills	Y / N Malaise (Unexplained Tiredness)
Y / N Unexplained Weight Change	Y / N Unexplained Muscle Weakness
Y / N Dizziness or Fainting	Y / N Night Pain/Sweats
Y / N Change in Bowel or Bladder Functions	Y / N Numbness / Tingling
Y / N Other / Describe _____	

Pg 2 History

Name: _____

Health History: Date of Last Physical Exam _____ Tests performed _____

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week _____ On disability or leave? _____ Activity Restrictions? _____

Mental Health: Current levels of stress High _____ Med _____ Low _____ Current psych therapy? Y / N

Activity/Exercise: _____ None _____ 1-2 days/week _____ 3-4 days/week _____ 5+ days/week

Describe _____

Have you every had any of the following conditions or diagnoses? circle all that apply/describe

- | | | |
|----------------------------|--------------------------|---------------------------------|
| Cancer | Stroke | Emphysema / Chronic Bronchitis |
| Heart Problems | Epilepsy / Seizures | Asthma |
| High Blood Pressure | Multiple Sclerosis | Allergies - list below |
| Ankle Swelling | Head Injury | Latex Sensitivity |
| Anemia | Osteoporosis | Hypothyroid / Hyperthyroid |
| Low Back Pain | Chronic Fatigue Syndrome | Headaches |
| Sacroiliac / Tailbone Pain | Fibromyalgia | Diabetes |
| Alcoholism / Drug Problem | Arthritic Conditions | Kidney Disease |
| Childhood Bladder Problem | Stress Fracture | Irritable Bowel Syndrome |
| Depression | Rheumatoid Arthritis | Hepatitis HIV / AIDS |
| Anorexia / Bulimia | Joint Replacement | Sexually Transmitted Disease |
| Smoking History | Bone Fracture | Physical or Sexual Abuse |
| Vision / Eye Problems | Sports Injuries | Raynaud's (cold hands and feet) |
| Hearing Loss / Problems | TMJ / Neck Pain | Pelvic Pain |
| Other / Describe _____ | | |

Surgical / Procedure History

- | | |
|---|--|
| Y / N Surgery for Your Back / Spine | Y / N Surgery for Your Bladder / Prostate |
| Y / N Surgery for Your Brain | Y / N Surgery for Your Bones / Joints |
| Y / N Surgery for Your Female Organs | Y / N Surgery for Your Abdominal Organs |
| Other / Describe _____ | |

OB/GYN History (females only)

- | | |
|--|--------------------------------------|
| Y / N Childbirth Vaginal Deliveries # _____ | Y / N Vaginal Dryness |
| Y / N Episiotomy # _____ | Y / N Painful Periods |
| Y / N C-Section # _____ | Y / N Menopause - when? _____ |
| Y / N Difficult Childbirth # _____ | Y / N Painful Vaginal Penetration |
| Y / N Prolapse or Organ Falling Out | Y / N Pelvic Pain |
| Y / N Other / Describe _____ | |

Males Only

- | | |
|---------------------------------|-------------------------------|
| Y / N Prostate Disorders | Y / N Erectile Dysfunction |
| Y / N Shy Bladder | Y / N Painful Ejaculation |
| Y / N Pelvic Pain | |
| Y / N Other / Describe _____ | |

<u>Medications - pills, injection, patch</u>	<u>Start Date</u>	<u>Reason for Taking</u>
_____	_____	_____
_____	_____	_____

<u>Over the Counter - vitamins, etc.</u>	<u>Start Date</u>	<u>Reason for Taking</u>
_____	_____	_____
_____	_____	_____

PELVIC SYMPTOM QUESTIONNAIRE**Bladder / Bowel Habits / Problems**

- | | | | |
|-------|---------------------------------------|-------|---------------------------------------|
| Y / N | Trouble Initiating Urine Stream | Y / N | Blood in Urine |
| Y / N | Urinary Intermittent / Slow Stream | Y / N | Painful Urination |
| Y / N | Trouble Emptying Bladder | Y / N | Trouble Feeling Bladder Urge/Fullness |
| Y / N | Difficulty Stopping the Urine Stream | Y / N | Current Laxative Use |
| Y / N | Trouble Emptying Bladder Completely | Y / N | Trouble Feeling Bowel/Urge/Fullness |
| Y / N | Straining or Pushing to Empty Bladder | Y / N | Constipation/Straining |
| Y / N | Dribbling After Urination | Y / N | Trouble Holding Back Gas/Feces |
| Y / N | Constant Urine Leakage | Y / N | Recurrent Bladder Infections |
| Y / N | Other / Describe _____ | | |

- Frequency of urination: awake hours _____ times per day, sleep hours _____ times per night
- When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
_____ minutes, _____ hours, _____ not at all
- The usual amount of urine passed is: _____ small _____ medium _____ large.
- Frequency of bowel movements _____ times per day, _____ times per week, or _____.
- When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
_____ minutes, _____ hours, _____ not at all
- If constipation is present describe management techniques _____
- Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated? _____ glasses per day.
- Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
_____ None Present
_____ Times Per Month (Specify if related to activity or your period)
_____ With Standing For _____ minutes or _____ hours
_____ Without Exertion or Straining
_____ Other

Skip questions if no leakage/incontinence.

9a. Bladder Leakage - Number of Episodes

- _____ No Leakage
 _____ Times Per Day
 _____ Times Per Week
 _____ Times Per Month
 _____ Only With Physical Exertion/Cough

9b. Bowel Leakage - Number of Episodes

- _____ No Leakage
 _____ Times Per Day
 _____ Times Per Week
 _____ Times Per Month
 _____ Only With Exertion / Strong Urge

10a. On average, how much urine do you leak?

- _____ No Leakage
 _____ Just a Few Drops
 _____ Wets Underwear
 _____ Wets Outerwear
 _____ Wets the Floor

10b. How much stool do you lose?

- _____ No Leakage
 _____ Stool Staining
 _____ Small Amount In Underwear
 _____ Complete Emptying

11. What form of protection do you wear? (Please complete only one)

- _____ None
 _____ Minimal Protection (Tissue Paper / Paper Towel / Pantishields)
 _____ Moderate Protection (Absorbent Product, Maxipad)
 _____ Maximum Protection (Specialty Product / Diaper)
 _____ Other _____

On average, how many pad/protection changes are required in 24 hours? _____ # of Pads