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. **I**f 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 symptoms. Check/circle all that apply

___ Sitting greater than________ minutes

___ With cough/sneeze/straining

___ Walking greater than ______minutes

___ Standing greater than _____ minutes

___ Changing positions (ie. - sit to stand)

___ Light activity (light housework)

___ Vigorous activity/exercise (run/weight lift/jump)

___ Sexual activity

___ With laughing/yelling

___ With lifting/bending

___ With cold weather

___ With triggers -running water/key in door

___ With nervousness/anxiety

___ No activity affects the problem

___ 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**____

<u>Health History</u>: 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 level of stress ___High ___Medium ___Low

Current psych therapy? ___Y ___N

Activity/Exercise: ___None ___1-2 days/week ___3-4 days/week ___5+ days/week

Describe ____

Have you ever 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 Ankle swelling	Multiple sclerosis Head Injury	Allergies-list below 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 problems	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____

Medications - pills, injection, patch	Start date	Reason for taking

____

Over the counter -vitamins etc	Start date	Reason for taking

____

____

____

____

Page 3 Symptoms **Name**_______________________________________

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

___Y ___N Trouble initiating urine stream

___Y ___N Urinary intermittent /slow stream

___Y ___N Trouble emptying bladder

___Y ___N Difficulty stopping the urine stream

___Y ___N Trouble emptying bladder completely

___Y ___N Straining or pushing to empty bladder

___Y ___N Dribbling after urination

___Y ___N Constant urine leakage

___Y ___N Blood in urine

___Y ___N Painful urination

___Y ___N Trouble feeling bladder urge/fullness

___Y ___N Current laxative use

___Y ___N Trouble feeling bowel/urge/fullness

___Y ___N Constipation/straining

___Y ___N Trouble holding back gas/feces

___Y ___N Recurrent bladder infections

___Y ___N Other/describe ____

1. Frequency of urination: awake hour's _____ times per day, sleep hours ____times per night

2. 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

3. The usual amount of urine passed is: ___small ___ medium___ large.
4. Frequency of bowel movements _____ times per day, ________times per week, or .

5. 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.

6. If constipation is present describe management techniques

7. 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.

8. 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.

___With 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

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