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 symptoms. Check/circle all that apply

___Sitting greater than _____minutes
___Walking greater than _____minutes
___Standing greater than_____minutes
___Changing positions (i.e sit to stand)
___Light activity (light housework)
___Vigorous activity/exercise (run/weight lift/jump)
___Sexual activity
___Other, please list_____

___With cough/sneeze/straining
___With laughing/yelling
___With lifting/bending
___With cold weather
___With triggers-running water/key in door
___With nervousness/anxiety
___No activity affects the problem

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
_____
_____
_____

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 level 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 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	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 problems	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/feet)
Hearing loss/problem | TMJ/neck pain | Pelvic pain
Other/Describe_____

Surgical/Procedure History

Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs
Other/describe_____

OB/Gyn History (females only)

Y/N Childbirth vaginal deliveries #___
Y/N Episiotomy #___
Y/N C-Section #___
Y/N Difficult childbirth #___
Y/N Prolapse or organ falling out
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause—when?___
Y/N Painful vaginal penetration
Y/N Pelvic pain
Y/N Other/describe_____

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Erectile dysfunction
Y/N Painful ejaculation
Y/N Other/describe_____

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

_____
_____
_____
_____
_____

Over the counter-vitamins, etc | Start date | Reason for taking

_____
_____
_____
_____
_____

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
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.
___Wither 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 physical exertion/cough

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