## Patient History

**Name** ____________________________________________________**DOB**_________**Age**___
**Date**_________

1. Describe the current problem that brought you here?__________________________
   __________________________________________________________
   ______________________

2. When did your problem first begin?______________________________________
   __________

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.__________
6. Describe the nature of the pain (i.e. constant burning, intermittent ache)____________
   __________________________________________________________
   ______________________

7. Describe previous treatment/exercises______________________________________
   __________________________________________________________
   ______________________

8. 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 (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers i.e. /key in door
___ With nervousness/anxiety
___ No activity affects the problem
___ Other, please list ____________________________________________________
____________

9. What relieves your symptoms?__________________________________________
   __________
________________________________________________________________
____________

10. 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 ________________________________________________________________

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

12. What are your treatment goals/concerns?____________________________________________

________________________________________________________________________

**Since the onset of your current symptoms have you had:**

Y/N Fever/Chills

Y/N Unexplained weight change

Y/N Dizziness or fainting

Y/N Change in bowel or bladder functions

Y/N Malaise (unexplained tirednes

Y/N Unexplained muscle weakness

Y/N Night pain/sweats

Y/N Numbness / Tingling

Y/N Other /describe______________________________________________________

Date of Last Physical Exam ___________ Tests performed_______________________________

________________________________________________________________________

**Pg 2 History** **Name** ________________________________________________**DOB ID#**______ ________**Age**___

**General Health:** Excellent Good Average Fair Poor Occupation _____________________ _______________

Hours/week___________ On disability or leave?________ Activity Restrictions? _________ _______________

**Activity/Exercise**: None 1-2 days/week 3-4 days/week 5+ days/week
Describe ______________________________________________________________________ _______________

**Mental Health**: Current level of stress High_ Med___ Low___ Current psych therapy? Y/N

**Have you ever had any of the following conditions or diagnoses? Circle all that apply**

| | | |
|---|---|---|
| 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 problems | Stress fracture | Irritable Bowel Syndrome |
| Depression | Acid Reflux /Belching | Hepatitis |
| 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 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/genital pain____________
Y/N Other /describe____________________________________________________________ _______________

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic/genital pain location ______________________________________________

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 / Symptoms**

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Strain or push to empty bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Blood in urine
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Trouble feeling bladder urge/fullness

Y/N Recurrent bladder infections
Y/N Painful urination

Y/N Blood in stool/feces
Y/N Painful bowel movements (BM)
Y/N Trouble feeling bowel urge/fullness
Y/N Seepage/loss of BM without awareness
Y/N Trouble controlling bowel urge
Y/N Trouble holding back gas/feces
Y/N Trouble emptying bowel completely
Y/N Need to support/touch to complete BM
Y/N Staining of underwear after BM

Y/N Constipation/straining _____% of time
Y/N Current laxative use -type ____________

Y/N Other/describe ______________________________________________

Describe typical position for emptying: ______________________________________________

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. The bowel movements typically are: watery ___ loose ___ formed___ pellets ___ other ______
6. 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.
7. If constipation is present describe management techniques ______________________________

8. 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.

9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
___None present
___Times per month (specify if related to activity or your menstrual period)
___With standing for __________ minutes or ___________hours.
___With exertion or straining
___Other________________________________________________________________________________

10a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

10b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

11a. On average, how much urine do you leak?
___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

11b. How much stool do you lose?
___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying
___ Other ___________________________

12. What form of protection do you wear? (Please complete only one)
___None
___Minimal protection (tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxi pad)
___Maximum protection (specialty product/diaper)
___Other _______________________________________________________________________________

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