SEARCY PHYSICAL THERAPY

PATIENT QUESTIONNAIRE: FEMALE PELVIC HEALTH

Name: _____ **Age:** _____ **DOB:** _____

Referring Doctor: _____ **Diagnosis:** _____

Have you received previous Physical Therapy for this problem? (circle) No OR Yes: (date):_____

Have you received other treatment for this problem? No OR Yes: (type)_____

Medical History (circle all that apply): heart problems / hypertension / diabetes / cancer / osteoporosis thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis rheumatoid arthritis / seizures / history of stroke / kidney problems / depression / hx of blood clots/DVT

Other:_____

Surgical History (list type & date): _____

_____

Gynecological History (fill in blanks or circle answer for all that apply): Number miscarriages_____

Number of pregnancies_____ . Number of vaginal deliveries_____ . Number of C-sections_____

Birthdates & weight of each baby: _____

History of sexually transmitted diseases: No OR Yes: (specify active infections)_____

History of chronic urinary / bladder / yeast infections? No OR Yes: (specify)_____

Any active infections at this time? No OR Yes: (specify type/treatment)_____

Approximate date last menstrual cycle:_____ Menopausal? No OR Yes(hormone replacement?_____)

(Circle any that apply): Feelings of pelvic heaviness / history of: fibroids / cysts / endometriosis

Current Medications: _____

Allergies: _____

Work Status: ☐ currently working ☐ retired ☐ temporarily off work ☐ unemployed ☐ other:

Location / type of work: _____

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Emergency Contact:

Name: _____ Daytime phone #: (____)_____ -_____

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How did you learn about us? ☐ friend ☐ physician ☐ internet ☐ advertisement ☐ other:

Date of your next doctor's appointment: _____

_____ _____

Patient's Signature **Date**

PELVIC HEALTH REHAB: SYMPTOM QUESTIONNAIRE

Urinary Symptoms: Check all that apply and fill in appropriate blanks.

___ Urgency: abnormally strong urges to urinate
___ Frequency: urinates _____ times per (circle one) hour / day.
___ Leaking: When I leak, it (circle all that apply)
dampens underwear / dampens outerwear / empties my bladder completely.
___ Leaking: I leak with (circle all that apply): a strong urge to urinate / lifting / coughing
laughing / sneezing / bending / standing up / opening door to house / parking car
on way to bathroom / walking / jogging/exercise / sexual intercourse / hear running water
other:_____
___ Leaking: I leak _____ times a (circle one) day / week.
___ Use of leakage protection (number per day): panty liner____ / pad____ / diaper_____
___ Wake at night to urinate: number of times each night: _____
___ Burning with urination
___ Abnormal stream (specify:_____)
___ Difficulty or hesitancy with emptying bladder

Other:_____

Fluid Intake: Fill in *average number of cups* (1 cup=8 ounces) of each for a normal day:

___ Water	____ Milk	____ Juice (specify:_____)
___ Soft Drinks	____ Decaf Soft Drinks	____ Tea
___ Decaf Tea	____ Coffee	____ Decaf Coffee
___ Alcohol	____ Other:_____	

Bowel Symptoms: Check all that apply and fill in blanks.

Number of bowel movements per (circle one) day / week : _____

___ Constipation: I frequently strain to move bowels because of this: Yes OR No
___ Take regular fiber supplements (type and frequency):_____
___ Frequent diarrhea
___ Irritable bowel syndrome
___ Lactose intolerance or other food allergy affecting bowels (specify other: _____)
___ Bowel leakage (circle all that apply): stains underwear / small amount / large amount
___ Bowel leakage (circle all that apply): I leak with lifting / coughing / laughing / sneezing /
bending / standing up / walking / jogging/exercise / sexual intercourse
other:_____
___ Bowel leakage: I leak _____ times a (circle one) day / week.
___ Use of leakage protection (number per day): panty liner____ / pad____ / diaper_____

Other: _____

Pain Symptoms:

Do you have pain? No OR Yes: location:_____
Describe how the pain feels: _____
When did pain first begin: _____
Are any of your normal activities limited by pain? No OR Yes: (specify)_____
What makes your pain worse?:_____
Better?: _____
Rate your pain on the following scale: 0=no pain at all, 5=moderate pain, 10=worst pain imaginable
At worst (circle one): 0 1 2 3 4 5 6 7 8 9 10 On average: 0 1 2 3 4 5 6 7 8 9 10

Goals you want to achieve through therapy (be specific): _____
_____