**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
4. Since that time is it: staying the[ ]  same [ ]  getting worse[ ]  getting better

Why or how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If pain is present rate pain on a 0-10 scale, 10 being the worst. Choose an item. Describe the nature of the pain (i.e. constant burning, intermittent ache) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Describe previous treatment/exercises \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Activities/events that cause or aggravate your symptoms. Check 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 trigger- running water/key

 in door

[ ]  With nervousness/anxiety

[ ]  No activity affects the problem

[ ]  Other, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Rate the severity of this problem from 0-10, with 0 being no problem and 10 being the worst Choose an item.
2. 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 tiredness)

Y/N Unexplained muscle weakness

Y/N Night pain/sweats

Y/N Numbness/Tingling

Y/N Other/describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History:**

Date of Last Physical Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test 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? Check all that apply/describe.**

[ ] Cancer

[ ] Heart problems

[ ] High Blood Pressure

[ ] Ankle swelling

[ ] Anemia

[ ] Low back pain

[ ] Sacroiliac/Tailbone pain

[ ] Alcoholism/Drug problem

[ ] Childhood bladder problems

[ ] Depression

[ ] Anorexia/bulimia

[ ] Smoking history

[ ] Vision/eye problems

[ ] Hearing loss/problems

[ ] Stroke

[ ] Epilepsy/seizures

[ ] Multiple sclerosis

[ ] Head Injury

[ ] Osteoporosis

[ ] Chronic Fatigue Syndrome

[ ] Fibromyalgia

[ ] Arthritic conditions

[ ] Stress fracture

[ ] Rheumatoid Arthritis

[ ] Joint Replacement

[ ] Bone Fracture

[ ] Sports Injuries

[ ] TMJ/neck pain

[ ]  Emphysema/Chronic bronchitis

[ ] Asthma

[ ] Allergies-list below

[ ] Latex sensitivity

[ ]  Hypothyroid

[ ] Hyperthyroid

[ ] Headaches

[ ] Diabetes

[ ] Kidney disease

[ ] Irritable Bowel Syndrome

[ ] Hepatitis HIV/AIDS

[ ] Sexually transmitted disease

[ ] Physical or Sexual abuse

[ ] Raynaud’s (cold hands and feet)

[ ] 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/NEpisiotomy # \_\_\_

Y/NC-Section # \_\_\_

Y/NDifficult childbirth # \_\_\_

Y/NProlapse 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,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 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 infection

Y/N Other/describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Frequency of urination: awake hours \_\_\_\_ times per day, sleep hours \_\_\_\_ time per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
3. [ ] minutes, [ ] hours, [ ]  not at all
4. The usual amount of urine passed is: [ ]  small [ ]  medium [ ]  large.
5. Frequency of bowel movements \_\_\_\_ times per day,\_\_\_\_ times per week, or \_\_\_\_
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.
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 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

10a. Bowel leakage- number of episodes

[ ]  No leakage

[ ]  \_\_\_\_ Times per day

[ ]  \_\_\_\_ Times per week

[ ]  \_\_\_\_ Times per month

[ ]  Only with exertion/strong urge9b. On average, how much urine do you leak?

[ ]  No leakage

[ ]  Just a few drops

[ ]  Wets underwear

[ ] Wets Outwear

[ ] Wets 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